99TH CONGRESS
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HOUSE OF REPRESENTATIVES

REPT. 99-337
Part 1

VETERANS' COMPENSATION AND HEALTH CARE AMENDMENTS OF 1985

OCTOBER 29, 1985.—Ordered to be printed

Mr. MONTGOMERY, from the Committee on Veterans' Affairs, submitted the following

REPORT

together with

SUPPLEMENTAL VIEWS

[To accompany H.R. 1538]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 1538) to amend title 38, United States Code, to provide a 4.1-percent increase in the rates of compensation and of dependency and indemnity compensation (DIC) paid by the Veterans' Administration, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE.

(a) SHORT TITLE.—This Act may be cited as the "Veterans' Compensation and Health Care Amendments of 1985".

(b) REFERENCES.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—COMPENSATION RATE INCREASES

SEC. 101. SHORT TITLE.

This title may be cited as the "Veterans' Compensation Rate Amendments of 1985".

SEC. 102. DISABILITY COMPENSATION.

(a) IN GENERAL.—Section 314 is amended—

(1) by striking out "$66" in subsection (a) and inserting in lieu thereof "$68";
(2) by striking out "$122" in subsection (b) and inserting in lieu thereof "$127";
(3) by striking out "$185" in subsection (c) and inserting in lieu thereof "$192";
(4) by striking out "$266" in subsection (d) and inserting in lieu thereof "$276";
(5) by striking out "$376" in subsection (e) and inserting in lieu thereof "$390";
(6) by striking out "$474" in subsection (f) and inserting in lieu thereof "$492";
(7) by striking out "$598" in subsection (g) and inserting in lieu thereof "$620";
(8) by striking out "$692" in subsection (h) and inserting in lieu thereof "$718";
(9) by striking out "$779" in subsection (i) and inserting in lieu thereof "$808";
(10) by striking out "$1,295" in subsection (j) and inserting in lieu thereof "$1,343";
(11) by striking out "$1,609" and "$2,255" in subsection (k) and inserting in lieu thereof "$1,669" and "$2,338", respectively;
(12) by striking out "$1,609" in subsection (l) and inserting in lieu thereof "$1,669";
(13) by striking out "$1,774" in subsection (m) and inserting in lieu thereof "$1,840";
(14) by striking out "$2,017" in subsection (n) and inserting in lieu thereof "$2,092";
(15) by striking out "$2,255" each place it appears in subsections (o) and (p) and inserting in lieu thereof "$2,338";
(16) by striking out "$968" and "$1,442" in subsection (r) and inserting in lieu thereof "$1004" and "$1,495", respectively;
(17) by striking out "$1,449" in subsection (s) and inserting in lieu thereof "$1,503"; and
(18) by striking out "$280" in subsection (t) and inserting in lieu thereof "$290".

(b) SPECIAL RULE. The Administrator of Veterans' Affairs may adjust administratively, consistent with the increases authorized by this section, the rates of disability compensation payable to persons within the purview of section 10 of Public Law 85-857 who are not in receipt of compensation payable pursuant to chapter 11 of title 38, United States Code.

SEC. 103. ADDITIONAL COMPENSATION FOR DEPENDENTS.

Section 315(l) is amended—
(1) by striking out "$79" in clause (A) and inserting in lieu thereof "$82";
(2) by striking out "$132" and "$42" in clause (B) and inserting in lieu thereof "$137" and "$44", respectively;
(3) by striking out "$54" and "$42" in clause (C) and inserting in lieu thereof "$56" and "$44", respectively;
(4) by striking out "$64" in clause (D) and inserting in lieu thereof "$66";
(5) by striking out "$143" in clause (E) and inserting in lieu thereof "$148"; and
(6) by striking out "$120" in clause (F) and inserting in lieu thereof "$124".

SEC. 104. CLOTHING ALLOWANCE FOR CERTAIN DISABLED VETERANS.

Section 362 is amended by striking out "$349" and insering in lieu thereof "$362".

SEC. 105. DEPENDENCY AND INDEMNITY COMPENSATION FOR SURVIVING SPOUSES.

Section 411 is amended—
(1) by striking out the table in subsection (a) and inserting in lieu thereof the following:

"Pay grade	Monthly rate	"Pay grade	Monthly rate
E-1	$494	W-4	$707
E-2	508	O-1	624
E-3	521	O-2	644
E-4	555	O-3	690

E–5	569	O–4	729
E–6	582	O–5	804
E–7	611	O–6	905
E–8	644	O–7	979
E–9	[1] 673	O–8	1,073
W–1	624	O–9	1,152
W–2	649	O–10	[2] 1,262

"[1] If the veteran served as sergeant major of the Army, senior enlisted advisor of the Navy, chief master sergeant of the Air Force, sergeant major of the Marine Corps, or master chief petty officer of the Coast Guard, at the applicable time designated by section 402 of this title, the surviving spouse's rate shall be $726.

"[2] If the veteran served as Chairman of the Joint Chiefs of Staff, Chief of Staff of the Army, Chief of Naval Operations, Chief of Staff of the Air Force, Commandant of the Marine Corps, or Commandant of the Coast Guard, at the applicable time designated by section 402 of this title, the surviving spouse's rate shall be $1,353".

(2) by striking out "$55" in subsection (b) and inserting in lieu thereof "$57";

(3) by striking out "$143" in subsection (c) and inserting in lieu thereof "$148"; and

(4) by striking out "$70" in subsection (d) and inserting in lieu thereof "$73".

SEC. 106. DEPENDENCY AND INDEMNITY COMPENSATION FOR CHILDREN.

Section 413 is amended—

(1) by striking out "$240" in clause (1) and inserting in lieu thereof "$249";

(2) by striking out "$345" in clause (2) and inserting in lieu thereof "$358";

(3) by striking out "$446" in clause (3) and inserting in lieu thereof "$463"; and

(4) by striking out "$446" and "$90" in clause (4) and inserting in lieu thereof "$463" and "$93", respectively.

SEC. 107. SUPPLEMENTAL DEPENDENCY AND INDEMNITY COMPENSATION FOR CHILDREN.

Section 414 is amended—

(1) by striking out "$143" in subsection (a) and inserting in lieu thereof "$148";

(2) by striking out "$240" in subsection (b) and inserting in lieu thereof "$249"; and

(3) by striking out "$122" in subsection (c) and inserting in lieu thereof "$127".

SEC. 108. EFFECTIVE DATE FOR RATE INCREASES.

The amendments made by this title shall take effect on December 1, 1985.

TITLE II—HEALTH-CARE ELIGIBILITY REFORM

SEC. 201. SHORT TITLE.

This title may be cited as the "Veterans' Health-Care Eligibility Reform Act of 1985".

SEC. 202. ELIGIBILITY FOR HEALTH CARE OF VETERANS WITH NON-SERVICE-CONNECTED DISABILITIES.

(a) HOSPITAL CARE AND NURSING HOME CARE.—(1) Subsection (a) of section 610 of title 38, United States Code, is amended to read as follows:

"(a) The Administrator shall furnish hospital care which the Administrator determines is needed and may (within the limits of Veterans' Administration facilities) furnish nursing home care which the Administrator determines is needed—

"(1) to any veteran for a service-connected disability;

"(2) to a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty, for any disability;

"(3) to a veteran who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation, for any disability;

"(4) to a veteran who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement described in such section, for any disability;

"(5) to a veteran as provided in subsection (e) of this section;

"(6) to a veteran who is a former prisoner of war, for any disability;

"(7) to a veteran of the Spanish-American war, Indian wars, Mexican border period, or World War I, for any disability.

"(8) to a veteran for a non-service-connected disability, if the veteran is unable to defray the expenses of necessary care; and

"(9) to a veteran for a non-service-connected disability if, in the case of hospital care (as well as nursing home care), the Administrator determines that the care may be provided within the limits of Veterans' Administration facilities.".

(2) Subsection (e)(1) of such section is amended by striking out "may be furnished hospital care or nursing home care" in subparagraphs (A) and (B) and inserting in lieu thereof "shall be furnished hospital care and may (within the limits of the Veterans' Administration facilities) be furnished nursing home care.".

(3) Such section is further amended by adding at the end the following new subsections:

"(f)(1) Except as provided in paragraph (2) of this subsection, the Administrator may not furnish hospital care or nursing home care under this section to a veteran who is eligible for such care solely because of subsection (a)(9) of this section unless the veteran agrees to pay the United States the lesser of—

"(A) the cost of furnishing such care, as determined by the Administrator; and

"(B) the amount of the inpatient Medicare deductible in effect on the date of the veteran's admission for such care.

"(2) A veteran may not be required to make a payment under paragraph (1) of this subsection for care furnished during any 12-month period to the extent that such payment would cause the total amount paid by the veteran under such paragraph for hospital and nursing home care furnished during that period and under section 612(f)(3) of this title for medical services furnished during that period to exceed the amount of the inpatient Medicare deductible in effect for services provided during the first month of such 12-month period.

"(3) An amount collected or received by the Veterans' Administration under this subsection shall be deposited in the Treasury as a proprietary receipt.

"(4) For the purposes of this subsection, the term 'inpatient Medicare deductible' means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)).

"(g) Nothing in this section—

"(1) requires the Administrator to furnish hospital care in a facility other than a Veterans' Administration facility;

"(2) requires the Administrator to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty to provide care in an institution of such government; or

"(3) restricts the Administrator's discretion to determine—

"(A) the appropriateness of furnishing medical services, therapies, or programs under this chapter; or

"(B) in what manner they will be furnished.".

(b) MEDICAL SERVICES FURNISHED ON AN OUTPATIENT OR AMBULATORY BASIS.—(1) Subsections (a) and (g) of section 612 are amended by striking ", within the limits of Veterans' Administration facilities, may" and inserting in lieu thereof "shall".

(2) Subsection (f) of such section is amended—

(A) by striking out "The Administrator, within the limits of Veterans' Administration facilities, may" and inserting in lieu thereof "(1) Except as provided in paragraph (3) of this subsection, the Administrator shall";

(B) by redesignating clause (1) as Clause (A) and redesignating subclauses (A) and (B) of such clause as subclauses (i) and (ii), respectively;

(C) by redesignating clauses (2) and (3) as clauses (B) and (C), respectively;

(D) by designating the second sentence as paragraph (2);

(E) by striking out the third sentence; and

(F) by adding at the end the following:

"(3)(A) The Administrator may not furnish medical services under paragraph (1) of this subsection or home health services under paragraph (2) of this subsection to a veteran who is eligible for such care solely because of section 610(a)(9) of this title unless the veteran agrees to pay to the United States, in the case of each visit in which such medical or home health services are furnished, the amount equal to 20 percent of the estimated average cost of an outpatient visit in a Veterans' Administration facility during the fiscal year in which the services are furnished. Such estimated average cost shall be determined by the Administrator.

"(B) Subparagraph (A) of this paragraph does not apply to services furnished under paragraph (1)(A)(ii) of this subsection.

"(C) A veteran may not be required to make a payment under this paragraph for services furnished under this subsection during any 12-month period to the extent that such payment would cause the total amount paid by the veteran under this

paragraph for medical services furnished during that period and under section 610(f) of this title for hospital and nursing home care furnished during that period to exceed the amount of the inpatient Medicare deductible in effect for services provided during the first month of such 12-month period.

"(D) For the purposes of this paragraph, the term 'inpatient Medicare deductible' means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)).

"(E) An amount collected or received by the Veterans' Administration under this paragraph shall be deposited in the Treasury as a proprietary receipt.".

(3) Subsection (i) of such section is repealed.

(4) Subsection (j) of such section is amended—

(A) by striking out "pursuant to" and inserting in lieu thereof "under";

(B) by striking out "(voluntarily requesting" and inserting in lieu thereof "who voluntarily request";

(C) by striking out the parenthesis after "immunizations";

(D) by striking out "facility, utilizing" and inserting in lieu thereof "facility. Any such immunization shall be made using";

(E) by striking out "Administration," and all that follows through "to provide" and inserting in lieu thereof "Administration. For such purpose, the Secretary may provide"; and

(F) by striking out "cost and the provisions of section" and inserting in lieu thereof "cost. Section".

(c) DETERMINATION OF ABILITY TO PAY.—Section 622 of such title is amended—

(1) by inserting "(a)" before "For the purposes";

(2) by striking out "610(a)(1)(B)" and inserting in lieu thereof "610(a)(8)"; and

(3) by adding at the end the following new subsection:

"(b)(1) An individual who does not qualify as having sufficient evidence of inability to defray necessary expenses by reason of subsection (a) of this section shall nevertheless be presumed to be unable to defray necessary expenses for the purpose of the sections referred to in that subsection if the individual's attributable income during the 12-month period preceding the date of the individual's application for care under one of those sections is not greater than the health-care income threshold.

"(2) Notwithstanding paragraph (1) of this subsection, the Administrator may refuse to determine that an individual is unable to defray necessary medical expenses for the purpose of the sections referred to in subsection (a) of this section if the corpus of the estate of the individual (and of the individual's spouse and dependent children, if any) is such that under all the circumstances (including consideration of the annual income of the individual and of such spouse and dependent children) it is reasonable that some part of the corpus of such estates be consumed for the individual's maintenance.

"(3) For purposes of this subsection, an individual's attributable income shall be determined in the same manner as the manner in which a determination is made of the total amount of income by which the rate of pension for such individual under section 521 of this title would be reduced if such individual were eligible for pension under that section.

"(4) For purposes of paragraph (1) of this subsection, the health-care income threshold for an individual—

"(A) in the case of an application for care made during the 12-month period beginning on December 1, 1985, is the amount equal to the product of—

"(i) 3.34, and

"(ii) the applicable current maximum annual rate of pension (as determined under paragraph (5) of this subsection); and

"(B) in the case of an application for care made during a 12-month period beginning on December 1 of a calendar year after 1985, is the amount in effect for purposes of this paragraph during the previous 12-month period increased by the percentage by which benefits have been increased under section 3112(a) of this title during that period.

"(5) For purposes of paragraph (4)(A)(ii) of this subsection, the current maximum annual rate of pension for a veteran is—

"(A) the amount in effect under section 521(b) in the case of a veteran who is unmarried (or married but not living with or reasonably contributing to the support of such veteran's spouse) and there is no child of the veteran in the custody of the veteran or to whose support the veteran is reasonably contributing; and

"(B) the amount in effect under section 521(c), in the case of a veteran who is married and living with or reasonably contributing to the support of such veter-

an's spouse or if there is a child of the veteran in the veteran's custody or to whose support the veteran is reasonably contributing.".

(d) CONFORMING AMENDMENTS.—(1) Section 525(a) is amended by striking out "and special priority with respect to such care and services under section 612(i)(5) of this title".

(2) Section 601 is amended—

(A) in paragraph (4)(C)(ii) by striking out "in clause (1)(b) or (2) of the first sentence, or in the third sentence," and inserting in lieu thereof "in paragraph (1)(A)(ii), (1)(B), or (1)(C)";

(B) in paragraph (6)(A)(i) by striking out "section 612(f)(1)(A)" and inserting in lieu thereof "section 612(f)(1)(A)(i)"; and

(C) in paragraph (6)(B)(ii) by striking out "section 612(f)(1)(B)" and inserting in lieu thereof "section 612(f)(1)(A)(ii)".

(3) Section 612A is amended—

(A) by striking out "clause (1)(b)" in subsection (b)(1) and inserting in lieu thereof "paragraph (1)(A)(ii)"; and

(B) by striking out "612(f)(2)" in subsection (e)(1) and inserting in lieu thereof "612(f)(1)(B)".

(4) Section 618(e) is repealed.

(5) Section 620(f)(1)(A)(ii) is amended by striking out "612(f)(2)" and inserting in lieu thereof "612(f)(1)(B)".

(6) Section 663(a)(1) is amended by striking out "612(f)(2)" both places it appears and inserting in lieu thereof "612(f)(1)(B)".

(e) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendments made by this section shall apply to hospital care, nursing home care, and medical services furnished after the end of the 60-day period beginning on the date of the enactment of this Act.

(2) The provisions of sections 610 and 622 of title 38, United States Code, as in effect on the day before the date of the enactment of this Act, shall apply with respect to hospital and nursing home care and medical services furnished after the end of such 60-day period to veterans who were furnished such care or services on the day before the end of such period, but only to the extent that such care or service is furnished with respect to the same spell of illness for which it was furnished on such day as determined by the Administrator.

(f) SUNSET PROVISION.—The amendments made by this section shall expire on October 1, 1988.

SEC. 203. RECOVERY OF THE COST OF CERTAIN CARE AND SERVICES.

(a) IN GENERAL.—Section 629 of title 38, United States Code, is amended to read as follows:

"§ 629. Recovery by the United States of the cost of certain care and services

"(a)(1) In any case in which a veteran is furnished care or services under this chapter for a disability described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable costs of such care or services (as determined by the Administrator under subsection (d)(c)(2)), from a third party to the extent that the veteran (or the provider of the care of services) would be eligible to receive reimbursement or indemnification for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

"(2) Paragraph (1) of this subsection applies to a non-service-connected disability—

"(A) that is incurred incident to the veterans' employment and that is covered under a workers' compensation law or plan that provides reimbursement for or indemnification of the cost of health care and services provided to the veteran by reason of the disability;

"(B) that is incurred as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations insurance;

"(C) that is incurred as the result of a crime of personal violence that occurred in a State, or a political subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such crime; or

"(D) that is incurred by a veteran who—

"(i) does not have a service-connected disability; and

"(ii) is entitled to care (or reimbursement for the expenses of care) under an insurance policy, contract, medical, or hospital service agreement, mem-

bership, or subscription contract, or similar arrangement for the purpose of providing, paying for, or reimbursing expenses for health services.

"(b)(1) With respect to the right provided in subsection (a) of this section, the United States shall be subrogated to any right or claim that the veteran (or the veteran's personal representative, successor, dependents, or survivors) may have against a third party.

"(2)(A) In order to enforce any right or claim to which it is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by the veteran (or the veteran's personal representative, successor, dependents, or survivors) against a third party.

"(B) The United States may institute and prosecute legal proceedings against the third party if—

"(i) an action or proceeding described in subparagraph (A) of this paragraph is not begun within 180 days after the first day on which care and services for which recovery is sought are furnished to the veteran by the Veterans' Administration under this chapter;

"(ii) the United States sends written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute such legal proceedings; and

"(iii) a period of 60 days has passed following the mailing of such notice.

"(c) The Administrator may compromise, settle, or waive a claim of the United States under this section.

"(d)(1) The Administrator may enter into contracts or agreements with individuals or organizations for services to recover or collect amounts due the United States under this section. Notwithstanding section 3302(b) of title 31, such a contract or agreement may provide that a fee an individual or organization charges to recover or collect amounts due the United States is payable from the amount recovered or collected. Any such contract or agreement shall provide that—

"(A) the Administrator retains the authority to—

"(i) resolve a dispute;

"(ii) compromise a claim;

"(iii) end collection action; and

"(iv) refer a matter to the Attorney General to bring a civil action; and

"(B) with respect to any such recovery or collection, the individual or organization is subject to—

"(i) section 552a(m) of title 5 and sections 3301 and 4132 of this title; and

"(ii) laws and regulations of the United States and of the States related to collection practices.

"(2) The amount that may be recovered by the United States under subsection (a) of this section may not exceed the lesser of—

"(A) an amount equal to the reasonable cost of the care and services furnished the veteran under this chapter, as determined by the Administrator; or

"(B) the maximum amount specified (as applicable)—

"(i) by the law of the State or political subdivision concerned; or

"(ii) by any relevant contractual provision to which the veteran was a party or was subject.

"(3) For the purpose of determining the reasonable cost of care and services under subsection (a)(1) of this section and paragraph (2)(A) of this subsection, the Administrator—

"(A) shall prescribe regulations; and

"(B) may enter into agreements with insurance, medical service, and health-plan carriers and contractors.

"(4) Regulations prescribed under paragraph (3) of this subsection shall be prescribed only after notice and opportunity for public comment.

"(5) A determination for the purposes of this subsection of the reasonable cost of care and services furnished a veteran under this chapter shall be made in accordance with regulations prescribed and agreements entered into under paragraph (3) of this subsection.

"(e) A veteran eligible for care or services under this chapter may not be denied such care or services by reason of this section.

"(f) No law of any State or of any political subdivision of a State, and no provision of any contract or other agreement entered into, renewed, or modified (including any modifications of premiums or coverage) after the date of the enactment of the Veterans' Health-Care Eligibility Reform Act of 1985, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under section 611(b) of this title.

"(g) Any moneys collected or received by the Veterans' Administration under this section shall be deposited in the Treasury as a proprietary receipt.

"(h) The Administrator shall make available clinical records of the Veterans' Administration for a veteran who is a beneficiary of any kind of policy, contract, agreement, or other arrangement which is referred to in subsection (a)(2)(D) of this section and with respect to which recovery or collection is sought under this section for inspection and review by the parties to such policy, contract, agreement, or other arrangement for the sole purpose of permitting such parties to verify that services for which recovery or collection is sought were furnished.

"(i)(1) For purposes of this section, the term 'third party' means—

"(A) a State or political subdivision of a State;

"(B) an employer or an employer's insurance carrier;

"(C) an automobile accident reparations insurance carrier;

"(D) an insurance, medical service, or health plan carrier; or

"(E) a contractor.

"(2) Such term does not include—

"(A) the insurance programs under parts A and B of title XVIII of the Social Security Act; or

"(B) a State plan for medical assistance approved under title XIX of such Act.".

(b) EFFECTIVE DATE.—(1) The amendments made by this section shall apply to care and services provided on or after the date of the enactment of this Act, but shall not affect any policy, contract, agreement, or other arrangement referred to in section 629(a)(2)(D) of title 38, United States Code, as amended by subsection (a), that was entered into before such date and is not modified or renewed on or after such date.

(2) For purposes of paragraph (1), the term "modified" includes any change in premiums or coverage.

SEC. 204. ACCEPTANCE OF VA BENEFICIARIES BY PROVIDERS WHO ACCEPT MEDICARE BENEFICIARIES.

(a) IN GENERAL.—Chapter 17 is amended by inserting after section 624 the following new section:

"§ 625. Requirement that providers accept Medicare and Veterans' Administration beneficiaries on similar basis and accept Veterans' Administration payments as payments in full

"(a) A non-Federal provider of hospital services to any Medicare beneficiary—

"(1) must accept Veterans' Administration beneficiaries on a similar basis; and

"(2) must accept payments made by the Administrator in accordance with Veterans' Administration regulations as payments in full.

"(b) Upon a finding by the Administrator, made in accordance with procedures developed in consultation with the Secretary of Health and Human Services, that a Medicare provider has failed to comply with subsection (a) of this section, the Administrator shall report such finding to the Secretary for possible corrective action or for possible termination of the provider's agreement with the Secretary entered into under the Social Security Act (42 U.S.C. 1395cc(a)). Thereafter, in addition to the bases for termination set forth in such Act, the Secretary may terminate such agreement with the provider if the Secretary determines that the provider has failed to comply with this section.

"(c) For purposes of this section, the term 'Veterans' Administration beneficiaries' means all veterans and other persons for whose hospital care outside Federal facilities the Administrator is authorized to pay.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 624 the following new item:

"625. Requirement that providers accept Medicare and Veterans' Administration beneficiaries on similar basis and accept Veterans' Administration payments as payment in full.".

SEC. 205. REPORT.

(a) REPORT ON PROVISION OF HEALTH CARE.—The Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report describing in detail—

(1) the number of veterans receiving health care from the Veterans' Administration during the report period;

(2) the number of veterans applying for health care from the Veterans' Administration during the report period who did not receive such care; and

(3) the reasons why veterans who applied for such care did not receive such care.

(b) DEADLINE FOR REPORT.—The report shall be submitted not later than 30 days after the end of the report period.

(c) REPORT PERIOD.—For the purposes of this section, the term "report period" means the 12-month period beginning on the effective date of the amendments made by section 202.

TITLE III—MISCELLANEOUS

SEC. 301. ADVISORY COMMITTEE ON AMERICAN INDIAN VETERANS.

(a) ESTABLISHMENT OF COMMITTEE.—The Administrator of Veterans' Affairs shall establish, by January 15, 1986, an advisory committee to be known as the Advisory Committee on American Indian Veterans (hereinafter in this section referred to as the "Committee").

(b) DUTIES.—The Committee shall examine and evaluate programs and other activities of the Veterans' Administration with respect to the needs of American Indian veterans. Such examination and evaluation shall include—

(1) an assessment of the needs of such veterans with respect to health care, rehabilitation, outreach, and other programs administered by the Veterans' Administration; and

(2) a review of the manner in which and the extent to which the programs and other activities of the Veterans' Administration meet such needs.

(c) MEMBERS.—The Committee shall consist of—

(1) the Secretary of Labor (or a representative of the Secretary of Labor designated by the Secretary after consultation with the Assistant Secretary of Labor for Veterans' Employment);

(2) the Chief Medical Director and Chief Benefits Director of the Veterans' Administration; and

(3) members appointed by the Administrator from the general public, including—

(A) representatives of American Indian veterans, including such veterans with service-connected disabilities; and

(B) individuals who are recognized authorities in fields pertinent to the needs of such veterans, including specific health care needs of such veterans and the delivery of health care services by the Veterans' Administration to such veterans.

(d) PARTICIPATION BY OTHER AGENCIES.—The Administrator may invite representatives of other departments and agencies of the Federal Government to participate in the meetings and other activities of the Committee.

(e) EXPENSES.—The members of the Committee appointed by the Administrator shall be paid for reasonable and necessary expenses, as determined by the Administrator, incurred in carrying out the duties of the Committee.

(f) REPORTS.—(1) Not later than November 1, 1986, and not later than November 1, 1987, the Committee shall transmit to the Administrator a report on the matters described in paragraphs (1) and (2) of subsection (b) that were examined and evaluated by the Committee during fiscal year 1986 in the case of the first report and during fiscal year 1987 in the case of the second report.

(2) Within 60 days after receiving each such report, the Administrator shall transmit to the Congress a copy of the report, together with any comments concerning the report that the Administrator considers appropriate.

(g) TERMINATION.—The Committee shall terminate on the date on which the second report is transmitted by the Committee pursuant to subsection (f)(1).

SEC. 302. AGENT ORANGE STUDY FOR FEMALE VETERANS.

(a) REQUIREMENT FOR EPIDEMIOLOGICAL STUDY.—(1) The Administrator of Veterans' Affairs shall provide for the conduct of an epidemiological study of any long-term adverse gender-specific health effects in females of service in the Armed Forces of the United States in the Republic of Vietnam during the period of the Vietnam conflict as such health effects may result from exposure to—

(A) phenoxy herbicides (including the herbicide known as Agent Orange); and

(B) the class of chemicals known as the dioxins produced during the manufacture of such herbicides.

(2) In providing for such study, the Administrator may expand the scope of the study to include an evaluation of any long-term adverse gender-specific health effects in females of such service as such health effects may result from other factors involved in such service (including exposure to other herbicides, chemicals, medications, or environmental hazards or conditions.

(3) The Administrator may also include in the study an evaulation of the means of detecting and treating adverse gender-specific health effects found through the study.

(4) The Administrator shall provide for the study to be conducted through contracts or agreements with public or private agencies or persons.

(b) FUNCTIONS OF OFFICE OF TECHNOLOGY ASSESSMENT.—(1) The study required by subsection (a) shall be conducted in accordance with a protocol approved by the Director of the Office of Technology Assessment.

(2) The Director shall monitor the conduct of such study in order to assure compliance with such protocol.

(3)(A) Concurrent with the approval or disapproval of any protocol under paragraph (1) the Director shall submit to the appropriate committees of Congress a report—

(i) explaining the basis for the Director's action in approving or disapproving the protocol; and

(ii) providing the Director's conclusions regarding the scientific validity and objectivity of the protocol.

(B) If the Director has not approved such a protocol during the 180 days following the date of the enactment of this act, the Director—

(i) shall submit to the appropriate committees of Congress a report describing the reasons why the Director has not given such approval; and

(ii) shall submit to such committees an update report on such initial report each 60 days thereafter until such a protocol is approved.

(4) The Director shall submit to the appropriate committees of Congress, at each of the times specified in the second sentence of this paragraph, a report on the Director's monitoring of the conduct of such study pursuant to paragraph (2). A report under the preceding sentence shall be submitted—

(A) before the end of the six-month period beginning on the date of the approval of the protocol by the Director;

(B) before the end of the 12-month period beginning on such date; and

(C) annually thereafter until the study is completed or terminated.

(c) DURATION OF STUDY.—The study conducted pursuant to subsection (a) shall be continued for as long after the submission of the first report under subsection (d)(1) as the Administrator may determine reasonable in light of the possibility of developing through such study significant new information on the long-term gender-specific adverse health effects in females of exposure to dioxins.

(d) REPORTS TO CONGRESS.—(1) Not later than 24 months after the date of the approval of the protocol pursuant to subsection (b)(1) and annually thereafter, the Administrator shall submit to the appropriate committees of Congress a report containing—

(A) a description of the results thus far obtained under the study conducted pursuant to such subsection; and

(B) such comments and recommendations for administrative or legislative action, or both, as the Administrator considers appropriate in light of such results.

(2) Not later than 90 days after the submission of each report under paragraph (1), the Administrator shall publish in the Federal Register, for public review and comment, a description of any action that the Administrator proposes to take with respect to programs administered by the Veterans' Administration. Each such description shall include a justification or rationale for any such action the Administrator proposes to take. Any such proposal shall be based on the results described in the report under paragraph (1) and the comments and recommendations on that report and any other available pertinent information.

(3) The requirement in paragraph (1) for the submission of annual reports expires upon the submission of a report after the completion of the study under subsection (a).

(e) BUDGET ACT PROVISIONS.—(1) This section does not authorize the enactment of new budget authority for a fiscal year before fiscal year 1987.

(2) A contract to carry out the study under subsection (a) may be entered into only to the extent that—

(A) appropriated funds are available to carry out the contract; or

(B) the contract provides that the obligation of the United States to make payments under the contract is contingent upon the availability of appropriated funds for such payments.

(f) DEFINITION.—For the purposes of this section, the term "gender-specific health effects in females" includes effects on female reproductive capacity, reproductive

organs, and reproductive outcomes, effects on female-specific organs and tissues, and other effects unique to the physiology of females.

Amend the title so as to read:

A bill to amend title 38, United States Code, to provide a 3.7 percent increase in the rates of compensation and of dependency and indemnity compensation (DIC) paid by the Veterans' Administration, to reform eligibility for health care provided by the Veterans' Administration, and for other purposes.

INTRODUCTION

In its fiscal year 1986 budget submission, the Administration requested funds for a 4.1% cost-of-living adjustment (COLA) for service connected disability compensation and dependency and indemnity compensation (DIC) programs.

On April 17, 1985, the Subcommittee on Compensation, Pension and Insurance conducted a hearing to review legislation concerning these programs. The subcommittee received testimony from the Veterans' Administration, the Disabled American Veterans, the Paralyzed Veterans of America, AMVETS, the American Legion, the Veterans of Foreign Wars, the Vietnam Veterans of America, Inc., the Non Commissioned Officers Association, the Gold Star Wives of America, Inc., the Retired Officers Association and the National Association of Military Widows.

Veterans' Administration witnesses testified that the Administration would support a compensation increase effective December 1, 1985, equal to that received by social security and non-service-connected pension beneficiaries.

On July 11, 1985, the subcommittee recommended H.R. 1538, as amended, to the full committee, which would provide for a 4.1% COLA to become effective December 1, 1985. The subcommittee amended the bill to provide that DIC be paid to the surviving spouse of a former Commandant of the Coast Guard at the same rate provided to surviving spouses of other military service chiefs. The subcommittee also amended the bill to establish an Advisory Committee on American Indian Veterans.

On February 7, April 23, and April 25, 1985, the Subcommittee on Hospitals and Health Care held hearings on various aspects of the Veterans' Administration's health care programs.

The subject of the February 7 hearing was the Veterans' Administration's Department of Medicine and Surgery fiscal year 1986 budget, including proposed cost saving legislation concerning reimbursement from third party insurance carriers for cost of medical care and treatment to veterans with non-service-connected disabilities, as well as the establishment of a means test for certain non-service-connected disabled veterans. Testimony was received from the Veterans' Administration.

On April 23 and 25, 1985, hearings were held to receive testimony concerning the "Older Veterans' Health Care Amendments" (H.R. 505), including the impact of the Administration's proposed means test and third party reimbursement legislation on the Department of Medicine and Surgery. Testimony was received from the Veterans' Administration; veterans' service organizations; the Department of Social Services, Bryn Mawr, PA; the National Association of Area Agencies on Aging, and the American Health Care Association.

On September 11, 1985, the full committee met to consider H.R. 1538 as amended by the Subcommittee on Compensation, Pension and Insurance. The committee amended the bill to: (1) provide a 3.7% COLA; (2) meet the target savings mandated by the Congress in the 1986 Budget Resolution conference agreement, and (3) require the Veterans' Administration to undertake a study of any long-term, adverse, gender-specific health effects in female veterans resulting from exposure to herbicides containing dioxin while serving in the Armed Forces in Vietnam.

By a vote of 14 to 12, the full committee, with a quorum present, ordered H.R. 1538, as amended, to be reported to the House for consideration.

Summary of the Committee Bill

TITLE I—COMPENSATION RATE INCREASES

H.R. 1538, as reported, would increase the rates of compensation effective December 1, 1985 by 3.7 percent for service-connected disabilities as well as dependency and indemnity compensation for surviving spouses and children of veterans who die of service-connected causes. The bill would also increase by 3.7 percent the aid and attendance allowance payable to eligible veterans and surviving spouses, the additional amounts for dependents and survivors, and the clothing allowance for certain veterans.

TITLE II—HEALTH-CARE ELIGIBILITY REFORM

The bill would reform and improve eligibility for veterans' health care in VA facilities. The Veterans' Administration would be required to provide inpatient and outpatient care to:

(1) service-connected disabled veterans;

(2) former prisoners of war;

(3) veterans exposed to certain herbicides and ionizing radiation;

(4) veterans of the Spanish-American War, Mexican border period or World War I;

(5) veterans in receipt of non-service-connected pension benefits; and

(6) a veteran with one dependent whose income does not exceed $25,000 (or $19,000 for a single veteran).

The bill would provide that non-service-connected disabled veterans with income above that shown in subparagraph (6) above may be provided VA inpatient and outpatient medical care provided: (1) space and resources are available, and (2) the veteran pays an amount equal to the initial inpatient deductible required under Medicare (estimated to be $492 in fiscal year 1986). The veteran would not be required to pay the $492 deductible more than once in a 12-month period. A determination as to whether a veteran would be required to pay the deductible would be based upon the same criteria and procedures used in determining annual income and net worth for non-service-connected pension purposes.

These provisions which affect eligibility for health care would expire on September 30, 1988, unless the Congress acts to extend

such care would be covered when furnished by private facilities; and (2) seizing of property without compensation.

Second, a comprehensive cost-billing system would be necessary in order for the VA to prepare charges for reimbursement.

Third, the Veterans' Administration has been reluctant to submit to "utilization review" mechanisms employed by insurers.

Finally, the shift of the costs of an unknown amount of medical care from Federal taxpayers to those who pay insurance premiums.

Reconciliation instructions

On August 1, 1985, the House and Senate reached agreement on the First Concurrent Budget Resolution for fiscal year 1986. The agreement required the Committee on Veterans' Affairs to report legislation on matters within its jurisdiction that would reduce budget authority and outlays by $300 million in fiscal year 1986, and by a total of $1.15 billion during fiscal years 1986 through 1988.

Despite its previous opposition to the concept of third-party recovery and means testing, the committee is confronted with a mandate by the Congress to achieve considerable savings and believes there are no other proposals that would produce equivalent savings which would not adversely affect ongoing veterans' benefits and services. Accordingly, in view of the repeated endorsement of third-party reimbursement by the Administration and others as well, and the need to achieve savings during the next three fiscal years, the committee is recomending legislation to authorize third-party recovery from health care insurers for non-service-connected disabled veterans who obtain health care in VA facilities and to reform eligibility for VA medical care.

DISCUSSION

Current rules on veterans health care eligibility

Under existing law, the provision of Veterans' Administration health care to all veterans is discretionary; if VA facilities are not available, any veteran may be denied needed care.

A distinction exists between eligibility for hospital, nursing home and outpatient care. Generally, a veteran who signs a statement that he or she is unable to defray necessary medical expenses is eligible for hospital or nursing home care. In addition, veterans with service-connected disabilities, former prisoners of war, veterans exposed to dioxin or ionizing radiation, and veterans who are sixty-five years of age or older are eligible for care if the Veterans' Administration has facilities to provide care, without regard to their ability to defray the costs.

Outpatient services are provided in more limited circumstances. A veteran who seeks treatment for a service-connected disability, has a service-connected disability rated 50% or more, or is a former prisoner of war is eligible for medical services on an outpatient basis for any disability. Existing provisions of law grant similar eligibility for outpatient care to veterans of World War I, the Mexican border period, the Spanish-American War, or to those who are entitled to increased pension based on the need of regular aid and attendance or by reason of being permanently housebound. All of

this date. In the event that such provisions do expire, the law governing eligibility will revert to that which is presently effective.

The bill would also (1) authorize the Veterans' Administration to bill private insurance companies for the care of non-service-connected disabled veterans who have insurance; (2) repeal the current provision of law that allows a veteran over the age of 65 to receive care in VA facilities regardless of such veteran's ability to pay for his or her care elsewhere; and (3) authorize VA to require non-federal health care providers that furnish hospital care and services to veterans to accept the same payment from VA for such services to veterans that is now accepted for Medicare purposes.

TITLE III—MISCELLANEOUS PROVISIONS

The bill would establish an Advisory Committee on American Indian Veterans and would require the Administrator of Veterans' Affairs to conduct an epidemiological study of long-term, adverse health effects, if any, in females who served in the Armed Forces of the United States in the Republic of Vietnam and who were exposed to herbicides containing dioxin during such service.

DISCUSSION OF THE COMMITTEE BILL

TITLE I—COMPENSATION AND DEPENDENCY AND INDEMNITY COMPENSATION

BACKGROUND

There were 2,241,173 veterans receiving disability compensation as of August 1985. The Veterans' Administration expenditures for disability compensation for fiscal year 1985 is expected to be $8.3 billion.

The following table shows by war period the number of veterans receiving compensation at each of the disability evaluations from 0 to 100 percent and at each statutory level. Also shown are the number of veterans suffering from selected disabilities:

SERVICE-CONNECTED DISABILITY COMPENSATION INFORMATION, PERSONS ON THE ROLLS AS OF END OF MARCH 1985

	Total	Vietnam	Korea	WW II	WW I	Peacetime
Total veterans on rolls	2,244,419	598,912	223,919	1,064,516	13,561	343,511
Male	2,215,390	591,926	221,946	1,054,605	13,359	333,554
Female [1]	29,029	6,986	1,973	9,911	202	9,957
Combined degree of disability: [2]						
0 compensable	24,810	889	6,784	13,911	187	3,039
10	884,003	236,069	78,705	417,500	2,866	148,863
20	355,548	103,383	34,593	156,892	3,466	57,214
30	313,408	78,466	30,259	157,676	1,954	45,053
40	184,746	51,297	18,942	89,985	1,157	23,365
50	111,709	29,452	10,949	57,222	904	13,182
60	116,787	27,690	13,330	60,134	998	14,635
Schedule	83,097	22,155	9,073	41,167	685	10,017
Unemployable	33,690	5,535	4,257	18,967	313	4,618
70	66,247	19,287	7,740	31,128	455	7,637
Schedule	42,822	13,790	4,522	18,998	295	5,217

SERVICE-CONNECTED DISABILITY COMPENSATION INFORMATION, PERSONS ON THE ROLLS AS OF END OF MARCH 1985—Continued

	Total	Vietnam	Korea	WW II	WW I	Peacetime
Unemployable	23,425	5,497	3,218	12,130	160	2,420
80	37,192	10,001	4,286	18,955	323	3,627
Schedule	20,661	5,601	2,155	10,851	210	1,844
Unemployable	16,531	4,400	2,131	8,104	113	1,783
90	13,996	4,595	1,596	6,423	78	1,304
Schedule	6,488	2,065	757	3,067	48	551
Unemployable	7,508	2,530	839	3,356	30	753
100	135,973	37,783	16,735	54,690	1,173	25,592
Total paid 100 percent rate equals 100 plus total unemployable	217,127	55,745	27,180	97,247	1,789	35,166
Type of disability:						
TB, lung, pleura	41,998	1,844	9,462	24,230	1,946	4,516
Psychological and neurological	453,306	105,850	40,527	241,533	2,489	62,907
Other	1,749,115	491,218	173,930	798,753	9,126	276,088
Additional awards: [3]						
Aid and attendance:						
Veterans	11,537	3,263	1,615	3,910	123	2,626
Spouses [1]	3,029	474	285	1,766	127	377
Housebound veterans	6,867	1,689	908	2,916	115	1,239
Anatomical loss—limbs	23,305	6,732	2,631	11,706	157	2,079
Single	20,745	5,495	2,336	10,914	148	1,852
Hand	4,166	771	477	2,465	38	415
Foot	16,579	4,724	1,859	8,449	110	1,437
Double	2,452	1,169	284	773	9	217
Hands	120	39	13	52	1	15
Feet	2,105	1,032	248	636	8	181
Hand and foot	227	98	23	85	0	21
Triple	84	59	8	11	0	6
Hand and feet	75	53	7	9	0	6
Hands and foot	9	6	1	2	0	0
Quadruple	24	9	3	8	0	4
Loss of use—limbs	35,752	10,968	4,575	14,896	120	5,193
Single	21,472	6,509	2,388	10,607	107	1,861
Hand	9,253	2,735	1,049	4,526	62	881
Foot	12,219	3,774	1,339	6,081	45	980
Double	11,174	3,546	1,720	3,520	12	2,376
Hands	326	69	55	141	0	61
Feet	8,413	2,609	1,351	2,553	8	1,892
Hand and foot	2,435	868	314	826	4	423
Triple	752	191	130	270	0	161
Hand and feet	698	177	120	251	0	150
Hands and foot	54	14	10	19	0	11
Quadruple	2,354	722	337	499	1	795
Special monthly compensation: [4]	141,805	32,774	21,826	65,204	1,106	20,895
K	84,000	22,904	9,911	38,740	683	11,762
L	5,365	1,254	683	2,413	110	905
L ½	2,415	924	318	801	12	360
M	2,454	672	363	1,005	29	385
M ½	2,305	771	353	839	6	336
N	684	142	95	329	9	109
N ½	392	129	50	168	1	44
O	438	127	66	132	0	113
P	1,796	651	249	628	8	260
Q	26,559	737	7,566	14,970	126	3,160
R1	6,826	2,344	973	1,805	5	1,699
R2	1,636	426	283	411	0	516
S	6,867	1,689	908	2,916	115	1,239
T	68	4	8	47	2	7
Terminations (2d quarter fiscal year 1985)	19,828	2,853	1,184	10,118	843	4,830
Death	14,196	1,142	1,099	9,883	830	1,242

SERVICE-CONNECTED DISABILITY COMPENSATION INFORMATION, PERSONS ON THE ROLLS AS OF END OF MARCH 1985—Continued

	Total	Vietnam	Korea	WW II	WW I	Peacetime
Other	5,632	1,711	85	235	13	3,588
Dependency:						
Veterans not entitled (6–20 percent)	1,264,361	340,341	120,082	588,303	6,519	209,116
Veterans entitled:						
No dependency (30–100 percent)	293,164	65,174	30,827	148,034	3,601	45,528
Dependents (30–100 percent)	686,894	193,397	73,010	328,179	3,441	88,867
Total dependents	1,105,461	454,436	106,078	371,718	3,488	169,741
Spouses	652,075	174,075	69,731	323,503	3,424	81,342
Children	445,078	277,011	34,994	46,174	64	86,835
Parents	8,308	3,350	1,353	2,041	0	1,564

[1] Estimated figures based on September 1984 data.

[2] Compensation is paid according to the combined degree of disability determined from the Schedule for Rating Disabilities. The rates of payment are defined in secs. 314 and 315, ch. 11, title 38, United States Code. Veterans who have schedular ratings from 60 through 90 percent and are judged unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities are classified as individually unemployable and compensated at the 100-percent disability compensation level.

[3] Aid and attendance and housebound awards are granted under the provisions of secs. 314 and 315 of ch. 11, title 38, United States Code. Aid and attendance covers those recipients requiring the services of an attendant as a result of incurring severely restrictive disabilities. Housebound covers those less incapacitated but still confined to their immediate surroundings.

[4] Additional payments for various combinations of catastrophic losses as defined in title 38, chapter 11, section 314, paragraphs k through t.

Notes: Data produced on an annual basis are not available for every issue of this publication.

Vietnam—Vietnam era—Aug. 5, 1964, through May 7, 1975. Korea—Korean conflict—June 27, 1950, through Jan. 31, 1955. WW II—World War II—Dec. 7, 1941, through Dec. 31, 1946. WW I—World War I—Apr. 6, 1917, through Nov. 11, 1918. Peacetime—Peacetime, including the post-Vietnam era.

The basic purpose of the disability compensation program, throughout its history, has been one of providing a measure of relief from the impaired earning capacity of veterans disabled as the result of their military service. The amount of compensation payable varies according to the degree of disability, which, in turn, is required by law to represent, to the extent practicable, the average impairment in earning capacity resulting from such disability or combination of disabilities in civil occupations.

To be eligible to receive disability compensation a veteran must have contracted a disease, suffered an injury which is not the result of willful misconduct, or aggravated an existing disease or injury in the line of duty during active duty service and have been discharged under other than dishonorable conditions.

The responsibility for determining a veteran's entitlement to service connection for a disability rests solely with the Veterans' Administration. This determination is based upon the service medical records or other evidence which may be presented to the Veterans' Administration by the veteran. The law provides that if a veteran had service of 90 days or more during time of war or after December 31, 1946, and develops a chronic or tropical disease to a degree of ten percent or more within 1 year of his discharge from such service, service connection may be granted by presumption. Service connection may be granted by presumption for active tuberculosis or Hansen's disease (leprosy) which becomes manifest to a degree of 10 percent or more within 3 years of a veteran's discharge from such service and for multiple sclerosis becoming manifest to a 10-percent degree within 7 years of a veteran's discharge from such service. In cases of prisoners of war, diseases related to nutritional deficiencies or anxiety states or psychosis which become manifest to a degree of 10 percent or more at any time after service, may be ganted service connection on a presumptive basis.

When a claim for service-connected disability benefits is received by the Veterans' Administration, that agency obtains the service medical records and the issue is generally decided based upon such records. If the service medical records do not establish that the disability was incurred in service, the veteran may submit evidence to substantiate the contention. Generally, this may be by statements from persons with whom the veteran served relating knowledge of the veteran's injury of disease. The Veterans' Administration also would consider the question of entitlement to service connection by presumption if the disability is a chronic disease becoming manifest within the prescribed period of time. In a veteran is granted service connection, the percentage of disability is generally based upon the findings of a VA examinataion. If a veteran with a service-connected disability should feel in some later year that the disability has increased in severity, evidence of this, usually a statement of recent medical treatment, may be presented to the Veterans' Administration to request re-evaluation of the disability. Should the Veterans' Administration deny service connection or deny a request for an increased rating, the veteran may appeal the denial decision to the Board of Veterans' Appeals provided the veteran notifies the agency of his or her disagreement with the decision within one year of the date of notification of the decision.

The law provides that a case involving a complex or controversial medical issue may be referred to a medical specialist outside of the Veterans' Administration for an advisory opinion. The law also provides that, if service connection for a veteran's disability has been in existence for 20 or more years, service connection may not be severed except in the case of fraud. The law further provides that a disability rated continuously at or above an evaluation for 20 or more years shall not thereafter be rated at a lesser evaluation.

The percentage of disability for a specific disability is assigned by the Veterans' Administration. That agency has established a "Schedule for Rating Disabilities" which is used as the guideline for the measuring of the degree of disability. Compensation is paid for disabilities at ratings of 10 percent, 20 percent, 30 percent, and so forth up to 100 percent. The amount of compensation payable for each percentage of disability is established by law. Additional compensation is payable for the loss of a limb, blindness, and other severe disabilities. Additional dependency allowance is payable to veterans with a rating of 30 percent or more for a spouse, minor children, or dependent parents.

Percent of increase in compensation rates

From 1917 through November 1984, the cumulative increase in the Consumer Price Index (CPI) is 766.4 percent. During the same period the cumulative increase in the compensation rate paid for the totally and permanently disabled service-connected unmarried veteran is 1518.7 percent.

Dependency and indemnity compensation for survivors of veterans who have died of service-connected causes

As of August 1985, there are 259,345 spouses and 52,833 children receiving dependency and indemnity compensation (DIC). These are

the survivors of more than 300,000 veterans who either died in service or who died of service-incurred causes. Over $1.9 billion is expected to be paid in fiscal year 1985 to the survivors. Widows and children of veterans who died of causes determined to be service-connected are entitled to receive monthly DIC.

The purpose of this benefit is to provide partial compensation to the designated survivors for the loss in financial support sustained as the result of the service-connected death. Income and need are not factors in determining a surviving spouse's or child's entitlement since the Nation assumes, in part, the legal and moral obligation of the veteran to support the spouse and children. Payments of DIC for surviving spouses are detemined on the basis of the veteran's service pay-grade and range from $476 monthly for the surviving spouse of an E–1 to $1,217 for the surviving spouse of an O–10. Surviving spouses are entitled to an additional $55 monthly for each child.

There is an additional allowance of $143 monthly which is payable to eligible surviving spouses who are patients in a nursing home or who are in need of the regular aid and attendance of another person.

Surviving spouses qualified for DIC who are not so disabled as to require the regular aid and attendance of another person but who, due to disability, are permanently housebound, may be granted a special allowance of $70 monthly in addition to the DIC rate otherwise payable.

If there is no surviving spouse receiving dependency and indemnity compensation benefits but there is a surviving child, the child is entitled to $240 monthly with additional benefits for other children.

When a service-connected disability is found to be the principal or contributory cause of death, such death is considered to be service connected. These determinations are made on a very liberal basis. For example, there are disabilities which by their very nature are so overwhelming that eventual death can be anticipated irrespective of co-existing conditions. Even though such a disability is non-service-connected and is the primary cause of death, consideration is given to whether the co-existing service-connected conditions were of such severity as to have been a material influence in accelerating death. Where death had been so accelerated, it will be considered service connected. The death of any veteran whose service-connected disabilities were the primary cause of death or contributed materially in producing death would, of course, render the survivor basically eligible for service-connected death benefits.

The same benefits provided for those entitled to DIC are also payable to surviving spouses or children of certain veterans whose deaths are not service-connected but who, at death, had been in receipt of total (100 percent) ratings for service-connected disabilities. It is necessary for entitlement under this provision that the 100 percent rating has been in effect continuously for at least 10 years at death; or continuously since service and for at least 5 years. A surviving spouse must have been married to a veteran for at least 2 years at the time of death before entitlement exists.

The following table shows by war period the number of surviving spouses and children of service-connected veterans in receipt of survivors' death benefits:

ACTIVE DEPENDENCY AND INDEMNITY COMPENSATION CASES

	DIC beneficiaries		
	Total	Widows	Children
Total	312,178	259,345	52,833
World War I	22,694	21,861	833
World War II	122,963	117,594	5,369
Korean conflict	29,008	26,503	2,505
Vietnam era	80,509	50,246	30,083
Spanish/American War	82	67	15
Mexican border period	1	1	
Indian War			
Civil war	2		2
Regular establishment	56,919	42,893	14,026

Historically, the Congress has increased compensation rates whenever there has been an appreciable increase in the cost-of-living index, since the rates are not indexed to the Consumer Price Index by law. This is necessary to ensure that inflation does not erode the purchasing power of those receiving compensation and DIC benefits.

DISCUSSION

The Administration's fiscal year 1986 budget request submitted earlier this year recommended a 4.1 percent cost-of-living allowance (COLA) for the service-connected disability compensation and dependency and indemnity compensation (DIC) programs. The 4.1 percent rate adjustment represented what was anticipated for the indexed non-service-connected pension program, based on the changes in the Consumer Price Index (CPI) from the third quarter of calendar year 1984 to the third quarter of calendar year 1985. The increase proposed by the Administration would become effective December 1, 1985.

In its report to the Committee on the Budget (March 15, 1985), the committee recommended that the First Concurrent Budget Resolution contain new budget authority and outlays for a 4.1 percent increase effective December 1, 1985. The resolution as passed by the House included a 4.1 percent increase as did the conference agreement.

In hearings before the Subcommittee on Compensation, Pension and Insurance on April 17, 1985, spokesmen for the Veterans' Administration testified that the Administration would support an increase equal to that received by social security and non-service-connected pension beneficiaries effective December 1 of this calendar year.

On July 11, the subcommittee recommended a 4.1 percent COLA, as proposed by the Administration.

On August 1, the House and Senate adopted the conference agreement to the First Concurrent Resolution on the Budget for fiscal year 1986. Under the agreement various committees of the

House and Senate were instructed to report changes in laws within their jurisdiction sufficient to reduce budget authority and outlays by specified amount during the next three fiscal years. The agreement directed the Committee on Veterans' Affairs to report a bill that would reduce budget authority and outlays by $300 million in fiscal year 1986, $400 million in fiscal year 1987 and $450 million in fiscal year 1988.

When the committee met on September 11 to consider H.R. 1538, as recommended by the Subcommittee on Compensation, Pension and Insurance, in order to carry out the instructions of the House and Senate, the chairman of the committee (Mr. Montgomery) and the ranking minority member (Mr. Hammerschmidt) proposed that the compensation and dependency and indemnity compensation COLA be set at 3.7 percent based on the most recent CPI projection. According to the Congressional Budget Office estimate, at the time H.R. 1538 was being considered by the full committee, social security and veteran pension beneficiaries were expected to receive a COLA between 3.4 percent and 3.7 percent, effective December 1, 1985. Subsequent to the September 11 order to report the bill to the House, the Labor Department announced that the CPI increase for the 12 months ending on September 30, 1985, was 3.1 percent.

Since the committee has always attempted to provide compensation and DIC beneficiaries at least the same COLA provided to social security and pension beneficiaries, and since the committee is instructed to save $1.15 billion over the next three years, the reported bill would provide a 3.7 percent COLA.

Should the proposed rate increase be enacted, the changes in compensation and DIC rates effective December 1, 1985 would be as follows:

PROPOSED COMPENSATION AND DIC RATES EFFECTIVE DEC. 1, 1985

Increase monthly rate	From—	To—
Percentage of disability or subsection under which payment is authorized:		
(a) 10 percent	$66	$68
(b) 20 percent	122	127
(c) 30 percent	185	192
(d) 40 percent	266	276
(e) 50 percent	376	390
(f) 60 percent	474	492
(g) 70 percent	598	620
(h) 80 percent	692	718
(i) 90 percent	779	808
(j) 100 percent	1,295	1,343
Higher statutory awards for certain multiple disabilities are also increased by the committee bill as follows:		
(k)(1) Additional monthly payment for anatomical loss, or loss of use of, any of these organs: 1 foot, 1 hand, blindness in 1 eye (having light perception only), one or more creative organs, both buttocks, organic aphonia (with constant inability to communicate by speech), deafness of both ears (having absence of air and bone conduction)—for each loss	62	62
(2) Limit for veterans receiving payments under (a) or (j) above	1,609	1,669
(3) Limit for veterans receiving benefits under (l) to (n) below	2,255	2,338
(l) Anatomical loss or loss of use of both feet, 1 foot and 1 hand, blindness in both eyes (5/200 visual acuity or less), permanently bedridden or so helpless as to require aid and attendance	1,609	1,669
(m) Anatomical loss or loss of use of both hands, or of both legs, at a level preventing natural knee action with prostheses in place or of 1 arm and 1 leg at a level preventing natural knee or elbow action with prosthesis in place or blind in both eyes, either with light perception only or rendering veteran so helpless as to require aid and attendance	1,774	1,840

PROPOSED COMPENSATION AND DIC RATES EFFECTIVE DEC. 1, 1985—Continued

Increase monthly rate	From—	To—
(n) Anatomical loss of both eyes or blindness with no light perception or loss of use of both arms at a level preventing natural elbow action with prosthesis in place or anatomical loss of both legs so near hip as to prevent use of prosthesis, or anatomical loss of 1 arm and 1 leg so near shoulder and hip to prevent use of prosthesis	2,017	2,092
(o) Disability under conditions entitling veterans to 2 or more of the rates provided in (l) through (n), no condition being considered twice in the determination, or deafness rated at 60 percent or more (impairment of either or both ears service-connected) in combination with total blindness (5/200 visual acuity or less) or deafness rated at 40 percent or total deafness in 1 ear (impairment of either or both ears service-connected) in combination with blindness having light perception only or anatomical loss of both arms so near the shoulder as to prevent use of prosthesis	2,255	2,338
(p)(1) If disabilities exceed requirements of any rates prescribed, Administrator of VA may allow next higher rate or an intermediate rate, but in no case may compensation exceed	2,255	2,338
(2) Blindness in both eyes (with 5/200 visual acuity or less) together with (a) bilateral deafness rated at 30 percent or more disabling (impairment of either or both ears service-connected) next higher rate is payable, or (b) service-connected total deafness of 1 ear or service-connected loss or loss of use of an extremity the next intermediate rate is payable, but in no event may compensation exceed	2,255	2,338
(3) Blindness with only light perception or less with bilateral deafness (hearing impairment in either 1 or both ears is service-connected) rated at 10 or 20 percent disabling, the next intermediate rate is payable, but in no event may compensation exceed	2,255	2,338
(4) Anatomical loss or loss of use of 3 extremities, the next higher rate in paragraphs (l) to (n) but in no event in excess of	2,255	2,338
(q) [This subsection repealed by Public Law 90-493.]		
(r)(1) If veteran entitled to compensation under (o) or to the maximum rate under (p); or at the rate between subsections (n) and (o) and under subsection (k), and is in need of regular aid and attendance, he shall receive a special allowance of the amount indicated at right for aid and attendance in addition to such rates	968	1,004
(2) If the veteran, in addition to need for regular aid and attendance, is in need of a higher level of care, a special allowance of the amount indicated at right is payable in addition to (o) or (p) rate	1,442	1,495
(s) Disability rated as total, plus additional disability independently ratable at 60 percent or over, or permanently housebound	1,449	1,503
(t) Additional monthly allowance for a veteran in receipt of compensation for a disability not evaluated more than 90 percent disabling who has suffered a service-connected loss or loss of use of an extremity evaluated not less than 40 percent and has suffered a nonservice-connected loss or loss of use of the paired extremity evaluated at no less than 40 percent	280	290

In addition to basic compensation rates and/or statutory awards to which the veteran may be entitled, dependency allowances are payable to veterans who are rated at not less than 30 percent disabled. The rates which follow are those payable to veterans while rated totally disabled. If the veteran is rated 30, 40, 50, 60, 70, 80 or 90 percent disabled, dependency allowances are payable in an amount bearing the same ratio to the amount specified below as the degree of disability bears to total disability. For example, a veteran who is 50 percent disabled receives 50 percent of the amounts which appear below:

	Increase monthly rate	
	From—	To—
If and while veteran is rated totally disabled and—		
Has a spouse	$79	$82
Has a spouse and child	132	137
Has no spouse, 1 child	54	56
For each additional child	42	44
For each dependent parent	64	66

	Increase monthly rate	
	From—	To—
For each child age 18–22 attending school	120	124
Has a spouse in nursing home or severely disabled	143	148

The following increases are provided for surviving spouses of deceased veterans whose deaths are service-connected and who are receiving dependency and indemnity compensation (DIC) payments:

Pay grade	From—	To—
E–1	$476	$494
E–2	490	508
E–3	502	521
E–4	535	555
E–5	549	569
E–6	561	582
E–7	589	611
E–8	621	644
E–9	[1] 649	[1] 673
W–1	602	624
W–2	626	649
W–3	644	668
W–4	682	707
O–1	602	624
O–2	621	644
O–3	665	690
O–4	703	729
O–5	775	804
O–6	873	905
O–7	944	979
O–8	1,035	1,073
O–9	1,111	1,152
O–10	[2] 1,217	[2] 1,262

[1] If the veteran served as sergeant major of the Army, senior enlisted advisor of the Navy, chief master sergeant of the Air Force, sergeant major of the Marine Corps, or master chief petty officer of the Coast Guard, at the applicable time designated by section 402 of this title, the surviving spouse's rate shall be $726.

[2] If the veteran served as Chairman of the Joint Chiefs of Staff, Chief of Staff of the Army, Chief of Naval Operations, Chief of Staff of the Air Force, Commandant of the Marine Corps or Commandant of the Coast Guard, at the applicable time designated by section 402 of this title, the surviving spouse's rate shall be $1,353.

When there is no surviving spouse receiving dependency and indemnity compensation, payment is made in equal shares to the children of the deceased veteran. These rates are increased as follows:

	Increase monthly rate	
	From—	To—
1 child	$240	$249
2 children	345	358
3 children	446	463
Each additional child	90	93

TITLE II—HEALTH-CARE ELIGIBILITY REFORM

BACKGROUND

Eligibility for VA medical care

In 1917, Congress enacted legislation which established the foundation for the modern system of Government-provided health care for veterans. Under the 1917 act, the provision of medical benefits was clearly mandatory; it provided that medical and hospital services "shall be furnished" to World War I veterans with service-connected injuries. (Public Law 90, 65th congress, 1st session, section 302(3)). During the four decades between the 1917 act and a 1957 law (Public Law 85–56, Veterans' Benefits Act) which codified title 38 of the United States Code, numerous other laws were enacted which mandated medical benefits for some veterans and authorized care for others.

The veterans' hospital system was administratively created in 1922 when 57 Public Health Service hospitals were transferred to the United States Veterans' Bureau, the agency which became the Veterans' Administration in 1930. In 1922, the mandatory services of the 1917 act were expanded to include hospital care for neuropsychiatric and tubercular diseases of veterans of the Spanish American War, the Philippine Insurrection, and the Boxer Rebellion. (Public Law 194, 67th Congress, 1st session, section 4).

Congress passed the World War Veterans' Act in 1924. This act added to veterans' health care benefits the authority to provide hospital care, insofar as "existing Government facilities permit", to veterans of any war, military occupation, or military expedition since 1897. This act gave preference to those unable to defray the expense of such medical care. (Public Law 242, 68th Congress, 1st session, section 202(10)).

Congress passed the so-called Economy Act, P.L. 2, in 1933. It authorized the Administrator "under such limitations as may be prescribed by the President, and within the limits of existing Veterans' Administration facilities, to furnish to men discharged . . . for disabilities incurred in the line of duty and to veterans of any war . . . domiciliary care where they are suffering with permanent disabilities, tuberculosis, or neuropsychiatric ailments and medical and hospital treatment for diseases or injuries." (Public Law 2, section 6, as amended by P.L. 78, 73d Congress, 1st session.)

Regulations were promulgated by the President under the Economy Act which established a priority system for hospital and domiciliary care with service-connected care generally having a higher priority than non-service-connected care. (Executive Order 6094 (Veterans Regulation No. 6) March 31, 1933.) The regulations provided that the Administrator "may" provide certain other medical services with no priority system. In 1934, the Congress added a provision requiring the Administrator to provide hospital and domiciliary care for veterans of any war who were unable to defray the expense of their medical care. The provision was stated as follows:

> . . . [A]ny veteran of any war who was not dishonorably discharged, suffering from disability, disease, or defect, who is in need of hospitalization or domiciliary care, and is

> unable to defray the expenses therefor (including transportation to and from the Veterans' Administration facility) shall be furnished necessary hospitalization or domiciliary care (including transportation) in any Veterans' Administration facility, within the limitations existing in such facilities, irrespective of whether the disability, disease, or defect was due to service. The statement under oath of the applicant on such form as may be prescribed by the Administrator of Veterans' Affairs shall be accepted as sufficient evidence of inability to defray necessary expenses. (Public Law 141, 73rd Congress, 2nd session, section 29.)

The VA's General Counsel reported in 1982:

> Despite its mandatory language, however, the 1934 amendment does not appear to have required the Administrator to change his system of priority for access to VA care. Under that system, care for service-connected disabilities was given priority over non-service-connected care, even though veterans with service-connected disabilities might be able to defray the cost of their care, and veterans with non-service-connected medical problems might not. The author of the amendment stated that the purpose of the amendment was to ensure that excess beds in VA hospitals did not remain vacant while indigent veterans could not obtain medical care.

The Veterans' Benefits Act of 1957, Public Law 85-56, recodified title 38, U.S. Code, and provided discretionary authority within limits of VA facilities for the furnishing of hospital care, domiciliary care and medical services.

In 1970, Public Law 91-500 was enacted. It contained a provision that all veterans who are 65 years of age or older, or less than 65 if in receipt of a non-service-connected pension, would no longer be required to sign a statement of inability to defray expenses of necessary hospital or domiciliary care to gain admission to a VA hospital or domiciliary for treatment of a non-service-connected disability.

In 1980, the Veterans' Administration Health-Care Personnel Act of 1980, Public Law 96-330, modified the provision of law that prohibited the Administrator from looking behind the veteran's statement of inability to pay. It excluded service-connected veterans and veterans eligible for Medicaid benefits from having to sign the statement under oath, in addition to those in receipt of pension benefits. As was stated in the House Report accompanying the legislation, "it is designed to allow the Administrator to determine whether certain veterans are able, based on outside income, or adequate private insurance coverage, or both, to receive treatment for non-service-connected disabilities outside the Veterans' Administration." (House of Representatives Report No. 96-958, p. 16, 96th Congress, 2d session.) The committee notes that, since that time, the VA has failed to implement regulations to "look behind the oath" for veterans under age 65.

Recovery of medical care costs from third party payors

Under existing law, a veteran is eligible for necessary hospital or nursing home care for a non-service-connected disability if he is unable to defray the expenses of such care. Veterans who are age 65 or older are entitled to such necessary care without regard to their ability to bear the cost of needed care.

The Veterans Administration has, from time to time, attempted to collect from private insurance companies for the cost of care provided in Veterans' Administration medical facilities to veterans with non-service-connected disabilities who have private insurance coverage. These efforts, for the most part, have been negated by the exclusionary clauses included in private health insurance contracts. These exclusionary clauses generally state that reimbursement will not be provided for care in government facilities or where the beneficiary covered by the policy has no obligation to pay. Since the VA does not normally directly charge its patients, this practice systematically excludes insured veterans, but leaves insurance companies with obligations to pay for medical care for the same person in private hospitals.

Several recommendations have been made that agencies of the Federal Government be enabled to recover the costs of medical care that it delivered to its beneficiaries who have contracts or agreements with third parties for payment of all or part of their medical care. The National Academy of Sciences in 1977 and the General Accounting Office in 1977 and 1985, for example, have recommended that the Veterans' Administration recover costs of care provided to certain non-service-connected veterans.

In 1962, the Congress granted the Federal Government an independent right of action to recover the reasonable value of hospital, medical, surgical, or dental care and treatment when the government is required or authorized to provide such care and treatment to a person injured under circumstances giving rise to third party liability, by means of Public Law 87-693, the Federal Medical Care Recovery Act (42 U.S.C. 2651-2653).

The Veterans' Administration Health Care Amendments of 1980, Public law 96-330, permitted the Administrator of Veterans' Affairs to look beyond the written oath testifying to inability to defray medical costs which is executed by non-service-connected veterans under age 65 seeking admittance to VA hospitals. At the time, the committee clearly stated that this change was in lieu of legislation authorizing recovery of the costs of VA medical care from insurers of veteran patients. The intent of the House in passing this change to 38 U.S.C. section 622 is clearly stated on page 294 of House Report No. 96-1167 as follows:

> The Committee on the Budget is aware that the proposed change in current law is the committee's alternative to third-party reimbursement. If a non-service-connected veteran under age 65 submits an application for treatment in a VA medical facility, and is not eligible for Medicaid or in receipt of pension benefits, he will be required to sign a statement or oath of his or her inability to defray the expense of hospital care outside the VA.

The Administrator will then determine, on a case-by-case basis, in conjunction with a medical determination, whether the veteran has health insurance and the scope and amount of benefits available. For example, if a veteran has high-option Blue Cross-Blue Shield insurance coverage and desires treatment for a minor disability or illness, the Administrator would probably determine that the veteran is able to pay the expense for care in a non-VA facility. On the other hand, if a veteran has the same coverage and the illness is terminal cancer or the illness would require expensive treatment and in all probability exhaust all of his financial resources, the veteran would be determined eligible for treatment in a VA facility.

In 1981, the Congress provided authority in 38 U.S.C. section 629 for the VA to recover the reasonable costs of care and services from a State (or a political subdivision thereof) employer, employer's insurance carrier, automobile accident reparations insurance carrier, or in situations arising under a State's "victims of crime" law, to the extent that the veteran, or the provider of care and services to the veteran, would be eligible to receive reimbursement for such care and services if they had not been furnished by the Veterans' Administration (Public Law 97-72).

Previous third party recovery proposals

The Veterans' Administration has on three occasions, under both Democratic and Republican administrations, submitted proposed legislation to the Congress to amend title 38 of the United States Code to provide for the right of the United States to recover the costs of hospital, nursing home or outpatient medical care furnished by the VA to veterans for non-service-connected disabilities to the extent that they have health insurance or similar contracts or rights with respect to such care.

In 1973, during the 93rd Congress, Chairman Dorn, for himself and Mr. Hammerschmidt, introduced by request H.R. 5936, a bill to require that certain veterans receiving hospital care from the VA for non-service-connected disabilities be charged for such care to the extent that they have health insurance or similar contracts with respect to such care and to prohibit the future exclusion of such coverage from insurance policies or contracts for other purposes. In 1975, during the 94th Congress, Mr. Satterfield, for himself and Mr. Hammerschmidt, introduced a similar bill, by request, H.R. 4009. In 1979, during the 95th Congress, the Veterans' Administration again sent forward to the Congress similar proposed legislation.

The committee has opposed these proposals in consideration of issues that have been raised during committee hearings on the matter and that can be summarized as follows:

First, insurers have raised constitutional questions, despite Department of Justice opinions to the contrary, that the proposal exceeds the powers of the Federal Government. The questions have been raised in particular reference to: (1) prohibiting the exclusion of the costs of VA outpatient or inpatient medical, hospital, and nursing home care for treatment of non-service-connected injuries or disabilities from coverage under such policies or contracts if

these veterans who are eligible for outpatient care may be denied such care if VA facilities are not available to provide care. Moreover, veterans with service-connected disabilities rated less than 50%, as well as all other non-service-connected veterans who allege inability to defray the cost of care, are eligible for outpatient services only to obviate the need for VA hospital care or to complete treatment begun in the hospital. Once again, the restriction of providing care "within the limits of VA facilities" applies, so that on a given day all eligible veterans, or 10% of eligible veterans, or, hypothetically, no eligible veterans may be provided necessary care.

Number of veterans eligible for health care and available resources

Although there are over 28 million living veterans, the VA estimates there are only 12 million veterans eligible for health care. This estimate is not precise because insufficient data exist on veterans' income and ability to defray necessary medical expenses. Further, in spite of attempts to measure the impact of various proposals to limit eligibility, there is no precise definition of the population of veterans presently eligible for VA health care.

Despite this lack of refinement in estimates of veterans eligible for VA health care, the Administration is evidently concerned about the costs that could be entailed in providing care to a large number of veterans who would be eligible once they reach age 65. The committee views the challenge of caring for the older veteran in more optimistic terms. If the population of eligible veterans was clearly defined, and if the Administrator was required to provide needed health care services to a precisely defined group, a more rational planning process would ensue.

If enacted, the committee bill would accomplish this goal. The committee believes that instead of trying to shrink the pool of eligible veterans without any mandate to provide care for those veterans who remain eligible, the Federal Government should clearly identify those veterans who, as a matter of policy, should receive health care, and mandate that they be provided care in VA facilities.

The most recent reports available to the committee indicate that there is an excess of VA hospital beds in most states. The VA has the capacity to respond in areas where there is a high demand for outpatient care by providing additional resources to meet such demands. Not only does the VA require adequate resources in order to meet the changing demand for health care, it is essential that the VA possess a resource allocation system that is responsive to the demands of service-connected, needy and other categories of eligible veterans. This requires bold and creative VA leadership coupled with a more precise definition of those for whom the VA should care. Consequently, the committee is proposing legislation that creates a mandate to provide care to a defined and limited number of veterans so that VA planners can manage available resources to meet the health care needs of a clearly deserving population of veterans.

The administration's proposed means test

When the Administration's budget for fiscal year 1986 was transmitted to the Congress in early February, it included a brief description of a proposed means test for veterans seeking health care.

First, the Administration proposed to continue to provide medical care, within the limits of VA facilities, to the following categories of veterans: (1) service-connected veterans, for any disability; (2) veterans who were prisoners of war; (3) veterans exposed to certain herbicides or ionizing radiation; (4) VA pensioners; (5) World War I, Spanish-American War, and Mexican border period veterans; and (6) veterans with an income level below twice the VA pension rate standard, estimated to be approximately $15,000 in 1986 for a veteran with one dependent, or approximately $11,400 for a single veteran. According to these budget documents, a means test would be applied to all other veterans.

Second, the Administration's proposal would exclude a veteran whose family income exceeds the threshold level until the veteran's out-of-pocket medical expenses exceed certain amounts. The amounts are not specified in the budget document.

Third, the Administration also proposed to repeal the existing provision of law which makes veterans over age 65 eligible for health care regardless of their financial means. Finally, the Administration informed the committee that it intended to propose legislation to require reimbursement from private insurance plans for care provided to veterans who have no service-connected disabilities.

Despite urgent requests for more specific information at several committee hearings regarding these legislative changes, the Veterans' Administration did not transmit its proposed means test legislation until April 18, 1985. The Administration's proposal concerning recovery from third party insurers was transmitted on May 7, 1985.

In the absence of any specific information on the proposed means test or its impact on veterans who use the VA health care system, the Subcommittee on Hospitals and Health Care requested the Congressional Budget Office to obtain further information regarding the Administration's proposal in order to estimate the impact of the means test. According to CBO, full implementation of the Administration's means test would eliminate approximately 15% of the 680,000 veterans who were expected to be hospitalized in VA facilities in FY 1986. The means test would also eliminate about 18% of the over three million veterans who are expected to receive outpatient care in FY 1986. Approximately 21,000 employees of the VA's Department of Medicine and Surgery would be eliminated by fiscal year 1987 if the Administration's proposal were adopted by the Congress and fully implemented.

The Veterans' Administration criticized the CBO analysis because of its failure to take into account unmet demand for VA health care.

The committee bill

After the Administration revealed its proposed means test, the committee determined that major parts of the plan were unaccept-

able for the reasons discussed below. Accordingly, the committee developed the following approach and rationale to health care eligibility reform.

Income threshold—The Congressional Budget Office noted that between 15% and 18% of current or expected users of the VA health care system would be excluded by the Administration's means test. The median family income for a family headed by a veteran is approximately $25,000. Only about 25% of families have incomes below $15,000. Considering the costs of medical care, the committee believes the Administration's proposed income threshold is unrealistically low and would exclude veterans who cannot afford private medical care. Based on these and other factors, the committee decided that an income threshold of $25,000 for a veteran with one dependent is more appropriate and that the threshold for a single veteran should be approximately $19,000. These amounts are approximately 3.34 times the levels established in the VA pension program. For each additional dependent, the income threshold would increase by approximately $3,200. The committee's selection of the higher income threshold is based on a belief that it is essential to adopt a uniform, national standard at a level allowing for the high cost of living in many major metropolitan areas, and in Alaska and Hawaii.

Method of determining income and assets—The Administration's proposed means test would base income determinations on standards used in VA's pension program, except for the exclusion of certain unreimbursed medical expenses. In determining whether a veteran's income is below the threshold, the Administration's proposal would not allow a veteran to deduct his or her medical expenses or those incurred for a spouse or dependent. Additionally, the test for determining whether a veteran has assets which would make him or her ineligible for health care is not specified in the Administration's proposal. The committee believes the current pension income and asset tests are well thought out and accepted by veterans. The committee believes that their application should be specifically required in the measure ordered reported by the committee.

"Spend-down" or expected medical expense contribution—The Administration's legislative proposal does not provide explicit information on this aspect of its means test. If a veteran's family income exceeds the income threshold, he or she would be expected to pay a share of this excess income for medical expenses. If a veteran's countable income, without deduction for medical care expenses, exceeds the income threshold by an insignificant amount, the admitting clerk would have no choice but to refer the veteran to another source for necessary care. After the veteran had paid a specified amount for his or her own medical care, an amount which increases progressively with income, the VA could provide necessary medical care.

The committee believes that the "spend down" requirement is unnecessarily complicated and would be very difficult and expensive to administer. The burden of proving that a veteran has made the expected medical expense contribution would fall on the veteran, creating an onerous record-keeping requirement. As an alternative, the committee bill would authorize the VA to treat veterans

whose income exceeds the revised income threshold, provided there is capacity to provide needed care, and provided the veteran agrees to pay an amount equal to the inpatient Medicare deductible, estimated to be $492 in 1986.

Commitment to providing health care

When compared with the Administration's proposal, the committee bill provides a major advantage to veterans. Under existing law, as well as under the Administration's proposal, an eligible veteran is unable to predict whether care will be available when needed. This uncertainty arises by virtue of the fact that under current law and under the Administrator's proposed means test the Administrator "may" provide care "within the limits of Veterans Administration facilities." There is no requirement that the Administrator do so. In contrast, the committee bill would require VA to provide health care to several categories of veterans.

The bill would require the Department of Medicine and Surgery of the VA to plan to care for all eligible veterans under a new section 610 of title 38, United States Code. The care would be provided in the VA facility where the veteran applied for admission, or another VA medical facility within a reasonable distance. The VA is also authorized to obtain care at Department of Defense (DOD) facilities where space is available, or, in the case of a service-connected disabled veteran, for a service-connected disability in a private facility on a contract basis. The committee proposal would not change current law regarding beneficiary travel.

The VA must understand that the intent of the committee is to mandate health care to a limited, defined group of veterans and to provide care to the extent possible to an additional group of veterans where space is available and where the veteran voluntarily agrees to pay a deductible. This intent is evidenced by the committee's substitution of the word "shall" for the word "may" in pertinent sections of law.

The committee bill would amend the basic eligibility requirements for veterans seeking hospital and outpatient treatment. The present six categories of veterans eligible for such health care would be revised and restated as nine separate categories. In addition, the current limitation on furnishing hospital care (but not nursing home care) "within the limits of Veterans' Administration facilities" would be made inapplicable to eight of the nine categories of eligible veterans.

The VA would be required to provide inpatient care to service-connected veterans; former prisoners of war; veterans exposed to certain herbicides in Vietnam; veterans exposed to ionizing radiation; VA pensioners; World War I, Spanish-American War, Mexican border period veterans and veterans who meet a specified income level. Under current law, a separate eligibility exists for veterans sixty-five years of age or older; the proposed revision would make no distinction between veterans over 65 years of age or those under 65.

A new separate category of eligibility would be established for veterans who served in World War I or two earlier conflicts, the Spanish-American War or the Mexican border period. An additional, all-inclusive category for veterans who do not fall into one of

the eight other categories would also be established; this last category would consist of those veterans whose income and assets exceed the income limitation and enable them to defray the costs of needed care. They would be required to pay an annual deductible in order to receive needed care. Such care could only be provided within the limits of VA facilities.

Under existing law, an eligible veteran who seeks hospital care at a particular VA medical center on a given day, and who is determined by the examining physician to be in need of inpatient care, is generally admitted to the medical center. If the facility is unable to provide necessary care, the veteran may be referred to a nearby VA facility which can provide the needed care. Yet, in other similar cases, the veteran may simply be told that the facility cannot provide needed care and he or she is turned away. In addition, some veterans who present themselves at a VA medical center and do not require immediate care are requested to return at a scheduled time in order that more urgently needed care can be provided to other veterans.

The committee expects that this referral and deferral process may have to be expanded and strengthened at some future date in order to accommodate the revised eligibility provisions of the committee bill. Clearly, there is capacity for more hospital and nursing home services at existing VA facilities. The VA is authorized by law to establish 125,000 hospital beds and nursing home beds, and is required to operate and maintain at least 90,000 hospital and nursing home beds. In 1970, the VA operated 166 hospitals and over 106,000 hospital and nursing home beds. In 1984, the VA operated 172 hospitals but only 88,915 hospital and nursing home beds. According to the VA's 1984 Annual Report, approximately 20% of these beds were empty on an average day. It can be seen, then, that despite the opening of six new facilities since 1970, the VA has reduced its number of operating beds by more than 17,000.

In addition to assuring that each medical center has the capacity to care for eligible veterans who require immediate care, the VA may have to improve its ability to locate other VA medical centers which can accommodate demand when it exceeds the capacity of a particular VA medical center. An expanded referral capability should not be limited to existing medical districts or even regional boundaries, since the proposed bill requires the Veterans' Administration to provide such care in VA facilities. It makes no sense to delay providing needed care in one location at the same time that another location has available capacity to provide necessary treatment. The VA will be required to treat the veteran, seek a bed a another VA facility within reasonable distance, locate a bed in a DOD hospital nearby or, where applicable, contract for such care. Since the VA is operating far fewer beds than authorized, it could expand its bed capacity within existing facilities should that become necessary.

Evidence of inability to defray expenses

The committee bill would add a new provision to existing law concerning evidence of an individual's inability to defray the cost of necessary medical care. Existing law provides that veterans who meet the eligibility criteria for Medicaid, VA pension, or who have

a service-connected disability are presumed to be unable to defray the cost of necessary medical care. A new category of presumptive eligibles would be added by the proposed committee bill. A veteran would be eligible for necessary medical care under the "unable to defray" category if his or her family's income is equal to or less than 3.34 times the maximum annual rate of pension payable to totally disabled veterans under chapter 15 of title 38, U.S. Code. The following chart illustrates the applicable income levels:

Status	Maximum annual pension rate	Maximum income for health care
Single	$5,709	$19,068
With 1 dependent	7,478	24,977
Each additional dependent	968	3,233

In determining a veteran's family income (referred to as "attributable income" in the bill), the Administrator would make such determination in the same manner used in determining income for the VA's pension program. The maximum income level for health care would be increased each year by the same percentage increase applicable to the maximum pension rate.

The VA pension rule pertaining to net worth limitations is substantially restated in the language of the bill, and is to be applied in essentially the same manner to medical care eligibility determinations. It provides that if a veteran or his immediate family have sufficient assets (referred to as the "corpus of the estate") which under all the circumstances, could reasonably be expected to be consumed in order to provide for the veteran's maintenance, then the veteran would be able to defray necessary medical expenses.

The Administrator, in implementing this rule, would follow the definition of "corpus of estate" as is done in adjudication of pension claims and would therefore include all real and personal property owned by the veteran except the veteran's dwelling, including a reasonable lot area, and personal effects suitable to and consistent with the veteran's reasonable mode of life. Under existing guidelines, an estate less than $25,000 would not ordinarily make a veteran ineligible for pension. Similarly, a rule of reason would have to be adopted to determine whether it is reasonable for a veteran to be required to sell some part of his or her real property in order to pay the required deductible. In no event would the veteran be required to dispose of his dwelling.

Veterans who are able to defray the cost of care

The provision of the committee bill pertaining to veterans who are able to defray the cost of care describes the amount of, and conditions under which an annual deductible would be paid. For inpatient care or nursing home care, the deductible would be equal to the lesser of the cost of care, or the inpatient deductible paid by persons who have Medicare coverage. A person insured under Medicare and admitted to a hospital is required to pay a deductible which is calculated by the Secretary of Health and Human Services in accordance with a formula set out in the Medicare authorizing statute. *See* 42 U.S.C. section 1395e (section 1813 of the Social

Security Act). The committee is advised that for fiscal year 1985 the deductible is $400; it is estimated by CBO to be $492 for fiscal year 1986.

A veteran would not be required to pay the inpatient deductible more than once in any twelve-month period. Moreover, under Medicare, a person who is hospitalized for more than 60 days is assessed an additional coinsurance payment for each additional day of care equal to 25% of the inpatient hospital deductible, after 90 days, the copayment rises to 50% of the inpatient hospital deductible for each additional day. This copayment requirement would not be applicable to veterans.

The total outpatient copayment payable in any twelve-month period would be capped at the deductible payable for an inpatient admission. The amount of the copayment per visit would be 20% of the estimated nationwide average cost of the VA outpatient visit during the fiscal year in which the services are furnished. Effective October 1, 1984, the VA established a charge of $75 for an outpatient visit for use in connection with recovery under the Federal Medical Care Recovery Act, 42 U.S.C. 2652. Although not specifically endorsing the method used to calculate this rate, the committee expects the charges established under this section would be based on cost data similar to those used to calculate this rate. The Administrator would be required to update the estimated average cost on an annual basis. The amount paid by a veteran for outpatient services during any twelve-month period would be credited to the inpatient deductible in the event that the veteran was admitted for inpatient treatment during the twelve-month period.

The committee strongly urges the Administrator to consider using commercial practices, such as accepting credit cards, in the implementation of the outpatient copayment requirement. This is to insure that the costs of such billings are minimized. Otherwise, the cost of such billings could exceed the amount collected.

Clarification of the requirement that care be provided

The committee bill would also restate in positive law existing VA policies affecting the provision of health care in VA facilities. The existing definition of VA facilities anomalously includes restrictions on eligibility for health care provided by private facilities under a contract with the Administrator. These restrictions on eligiblity are made applicable to veterans by virtue of references to care in "Veterans' Administration facilities" in the sections of law which govern eligibility for hospital, nursing home, domiciliary, and outpatient care. By revising the language governing the eligibility for such care, the committee does not intend to alter the restrictions in existing law on providing contract care. The committee believes that although these restrictions are in need or revision for clarity and ease of understanding, such revision may provoke further misunderstanding if included in a bill which substantively modifies other provisions affecting health care eligibility.

The committee has also included language which clarifies existing policies of the VA regarding the treatment of individuals who are entitled to care from another government agency. Veterans who are incarcerated, or who are committed by order of a civil or criminal court of appropriate jurisdiction, are two examples of indi-

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viduals who are entitled to care from another government agency. While these veterans may be technically eligible for VA care, the agency has not accepted their applications because of its inability to guarantee the safety of other patients and because of its inability to insure that such patients do not leave without authorization. The committee bill does not affect this policy.

Similarly, the Administrator has always been authorized to determine when care is to be provided, the type of care provided, and to prescribe limitations on the types of medical care to be furnished. The committee's intent in restating this authority is to make it clear that current Agency authority remains in full force and effect.

Effective date

The provisions of the committee bill would apply to hospital care, nursing home care and medical services furnished more than 60 days after enactment. However, a veteran in an inpatient or outpatient status on the day before the effective date would not be affected by the revised eligibility or deductible provisions for care furnished in connection with a spell of illness for which treatment was furnished prior to the effective date.

The committee bill would also repeal the existing schedule of priority for outpatient care since the schedule is inconsistent with the committee's intent that the Administrator shall provide care to all eligible veterans.

The provisions of the bill which affect eligibility for health care would expire on September 30, 1988. Should Congress fail to extend or make the eligibility reform provisions permanent, the law governing eligibility will revert to that which is presently in effect.

Third party recovery

The Veterans' Administration Health-Care Personnel Act of 1980, P.L. 96-330, modified the provision of law that prohibited the Administrator from looking behind a veteran's statement under oath that he or she was unable to defray necessary medical expenses. As was stated in the House Report accompanying the legislation, the modification was "designed to allow the Administrator to determine whether certain veterans are able, based on outside income, or adequate private insurance coverage, or both, to receive treatment for non-service-connected disabilities outside the Veterans' Administration." (House of Representatives Report No. 96-958, p. 16, 96th Congress, 2d session). The committee clearly stated that the change was being made in lieu of legislation authorizing recovery of the costs of VA medical care from insurers of veteran patients. The VA failed to carry out the intent of Congress by not implementing this provision of law.

In considering the previous obejctions of the committee to a third-party recovery authority for the VA, the committee notes the following:

First, in a letter to the Chairman of the Senate Committee on Veterans' Affairs dated April 26, 1985, the Acting Assistant Attorney General, Philip D. Brady, reiterated the Department of Justice's long-held view that there is no constitutional prohibition against seeking reimbursement from third-party payers. Earlier ex-

pressions of the Department's views on this matter are contained in a letter dated April 14, 1979, to the Honorable Alan Cranston, Chairman, Senate Committee on Veterans' Affairs, from Patricia M. Wald, Assistant Attorney General, and in a letter dated June 11, 1973, to Paul H. O'Neill, Associate Director for Human and Community Affairs, Office of Management and Budget, from Robert G. Dixon, Jr., Assistant Attorney General. Mr. Brady wrote:

> [W]e strongly adhere to our view that the proposed legislation is constitutional . . . [T]he proposed legislation . . . is, in our view, well within the Government's power to regulate Congress may reasonably determine that it is in the public interest to spread part of the cost of providing this health care among all persons (or all veterans) with health insurance in order to preclude either a windfall to the health insurance companies or a government financial benefit to nonveteran policyholders.
>
> . . . Far from "taking" property belonging to private parties, the proposed legislation simply determines how government subsidies will be allocated in the future. The proposed legislation operates in classic regulatory fashion in that it governs only future conduct and allows private insurers (and all others affected) to adjust their behavior in light of the regulation.

The committee has designed its legislation in a manner consistent with the Administration's approach addressed by the Justice Department opinion.

Second, the feared shift on the costs of VA care of premium payers appears to be minimal. According to the General Accounting Office, a premium increase of between $.93 and $2.69 per year is expected for each of the approximately 112 million policyholders with comprehensive hospitalization insurance coverage if the companies pass on benefit payments and administrative costs to all of their policyholders.

Third, the committee expects that the need expressed by the VA for a cost billing system will be met by the diagnostic related group resource allocation system being established in the VA, which will enhance its ability to negotiate costs with insurers. The Department of Medicine and Surgery has expended substantial funds and staff resources in providing an extensive computer system in each hospital which can be used to support their billing and collection efforts.

Last, the utilization review within the VA provides a basis for working with insurers with related features of their contracts, policies or other arrangements.

Revision to existing law

The ~~right of the United States to recover~~ the cost of certain care and services from third parties would be revised by the bill. It would restate the existing provisions of law without substantive modification except for the addition of a new category of care for which the United States may seek recovery. Both the existing and proposed law apply only to care and services for non-service-connected disabilities. The new category is for care provided to a veter-

an with no service-connected disability who is entitled to care, or reimbursement for care, from a third party such as an employee health care insurer. This authority would be in addition to the Administrator's existing authority to collect under workers' compensation laws, automobile "no-fault" insurance policies, and "victims of crime" compensation funds.

The committee is aware that the United States has had to litigate the meaning of the existing provisions of law on several occasions where third parties sought to read the language in a manner inconsistent with Congressional intent. The repetition of terms used in existing law in the revision of this section is intended to signify that there is no change with respect to these terms from the original Congressional intent in enacting this measure.

In allowing recovery from third parties for the cost of care or treatment furnished by the Veterans' Administration, the law presently creates an independent right in the Government which it may enforce by subrogation, intervention, or a separate action. The nature of the Government's right is similar to that conferred by the Federal Medical Care Recovery Act, 42 U.S.C. § 2651. The language in the committee bill does not affect or diminish the Government's right to action, nor would the Government lose its right to recovery if it does not intervene in an action that is commenced within 180 days. The language in the committee bill protects the injured person's right to recover from damages incurred, but it is not intended to prevent an independent action if a timely action by the veteran is not brought.

Since the United States' authority to recover is limited to the extent that the veteran is entitled to reimbursement for indemnification for care or services, the amount that the United States may collect under the authority of this section is limited to the reasonable cost of the care provided less any applicable insurer-required deductible or copayment amount. Similarly, if a State law or a relevant contractual provision to which a veteran is subject sets a maximum amount which an individual is entitled to recover, regardless of the provider of services, then the United States would not be able to recover beyond that amount since it is the amount which the veteran may be reimbursed. However, during markup of the bill, the Chairman of the Subcommittee on Hospitals and Health Care (Mr. Edgar) offered an amendment, which was adopted by the committee, to clarify that the phrase "to the extent that the veteran . . . would be eligible to receive reimbursement or indemnification for such care" means that no third party payer would be required to reimburse the VA for a health care service that is not covered under the terms and conditions of its contracts, policies or other agreements with veterans. Of course, third party payers would no longer be able to refuse to reimburse based on a general exclusion of care provided by the VA.

The Veterans' Administration would not be authorized to bill a third party payer for the cost of care covered by the deductible which a veteran is required to pay to the VA in order to receive needed care. However, a veteran who pays the deductible in order to receive inpatient or outpatient care would not be responsible for any additional amount which would be payable under the terms of his or her insurance policy.

The Administrator would be authorized by the revised provision to waive, settle, or compromise any claim of the United States pursuant to this section. This is intended to clarify the Aministrator's authority in this regard. Prior to the enactment of the Federal Claims Collection Act of 1966, the VA had exercised its general authority to pursue and compromise claims. However, the passage of the Federal Claims Collection Act would be construed as limiting the Administrator's authority to settle claims. Since there was no stated intent to do so, a statutory restatement of this authority is desirable from the Administration's point of view.

Exclusionary clauses prohibited

The bill would effectively nullify any contract provision agreed to after the date of enactment of this measure which seeks to bar the United States from recovery in connection with care furnished in the circumstances described in the bill. This prohibition is intended to have a prospective effect, and is not designed to impair any existing contractural arrangements which are not described in the revised section 629.

Authority to contract for services

The committee bill contains language patterned after section 3718 of title 31, United States Code. The language is included in order to make it clear that the Administrator may enter into a contract with an organization that retains a portion of the amount collected as a fee for its services. The organization would be subject to the Privacy Act of 1974, 5 U.S.C. § 552a, the Fair Debt Collection Practices Act, 15 U.S.C. § 1692 *et seq.*, and other State and Federal laws related to collection practices. The Administrator would retain the authority to resolve the debt in any manner without protest from the collection organization.

The bill would require the Administrator to promulgate regulations for determining the reasonable cost of care and services. The Administrator would also be authorized to contract with consultants or other contractors to assist in determining reasonable costs.

Access to records

Third parties will have access to clinical records for the purpose of verifying that services which are billed were in fact furnished. The confidentiality restrictions found elsewhere in title 38, United States Code, are applicable to these records in all respects not addressed by this subsection. Thus, disclosure of records subject to the special protections found in 38 U.S.C. 4132 would have to be made in accordance with the provisions of that section. As a matter of policy, the committee believes that insurers should make every effort to obtain a veteran's consent to disclosure of information concerning treatment provided at a VA medical facility.

The bill defines the term "third party" to mean a State or political subdivision of a State, an employer, an employer's insurance carrier, an automobile accident reparations insurance carrier (terms used in the existing law), insurance medical service, or health plan carrier, or contractor. These latter terms are intended to cover health insurance policies or similar contracts.

This definition specifically excludes Medicare or Medicaid (or similar State plans under title XVIII of the Social Security Act) from this section's coverage; therefore, recovery may not be sought for care where the source of reimbursement is Medicare or Medicaid. It is also the committee's intent to prohibit private insurance companies from seeking to collect from Medicare or Medicaid in instances where such programs are first payers. In the event the veteran has both Medicaid and private health insurance, the private health insurance would be payable in accordance with its terms, but no reimbursement from Medicare or Medicaid could be obtained by the VA or the private insurance company.

The revised law will be applicable to care and services provided on or after the date of enactment but it would not affect agreements that were entered into before the date of enactment. However, any modification or renewal of the policy subsequent to the date of enactment, including a change in the premium rate, would have the effect of voiding any exclusionary clause applicable to care provided in a Veterans' Administration medical facility.

Cap on contract care reimbursement rates

The committee bill would add a new section to chapter 17 of title 38, United States Code. The proposed new section would require non-federal providers of hospital services to Medicare beneficiaries to accept Veterans' Administration beneficiaries on a similar basis. It would also require such providers to accept payments made by the Administrator in accordance with VA regulations as payments in full. In the event that a provider did not comply with these requirements, the Administrator could then initiate proceedings to enforce compliance through the Secretary of Health and Human Services.

Report on effect of committee bill

The bill would require the Administrator to provide the Committees on Veterans' Affairs of the Senate and House of Representatives with a report on the effects of the eligibility reforms contained in the bill. The report should include, but not be limited to, the following: First, the number of veterans receiving health care from the VA during the report period, including the existence and extent of policies, contracts, or other arrangements with third parties for the purpose of providing, paying for, or reimbursing expenses for health services and, second, the number of veterans applying for health care from the VA during the report period, including the extent and existence of third party reimbursement arrangements and reasons why veterans who applied for care did not receive such care. It is the committee's intent that this reporting requirement not foster the growth of extraordinary data collection operations. Instead, the committee expects that the management information required by the report will be provided through the decentralized hospital computer program in the various medical facilities and other management information programs that exist in the VA.

With regard to the context for this report, the committee understands that the National Center for Health Services Research in the Department of Health and Human Services will conduct, in the

near future, a survey of the use and cost of health care services in the United States, including the health care system of the VA. Several federal agencies are expected to participate and the committee strongly urges the VA to become part of this collaborative venture.

TITLE III—MISCELLANEOUS PROVISIONS

DISCUSSION

Advisory Committee on American Indians

The committee bill would direct the Administrator of Veterans' Affairs to establish an Advisory Committee on American Indians consisting of the Secretary of Labor, the Chief Medical Director and the Chief Benefits Director of the Veterans' Administration, representatives of American Indian veterans (including those with service-connected disabilities) and individuals from the general public who are recognized authorities in fields pertinent to the needs of such veterans.

American Indians have played prominent roles in the military history of this country since its very beginnings, nearly 200 years ago. On March 13, 1778, George Washington wrote from Valley Forge to the Commissioners of Indian Affairs: ". . . I am empowered to employ a body of four hundred Indians, if they can be procured upon proper terms . . . I think they may be made of excellent use, as scouts and light troops mixed with our own parties." During the Civil War, Indian regiments fought in both the Union and Confederate armies. Following the Civil War, Indians became part of the enlisted ranks of the U.S. Army where previously they had been hired as civilian auxiliaries and for scouting duty. On August 1, 1866, the U.S. Indian Scouts were established by order of the War Department. Regular enlisted men of the Army, the Scouts received the same pay and allowances and wore the same uniforms as their fellow servicemembers.

Continuing the traditions of their ancestors, many Indians served with distinction in the Army and other services during World Wars I and II, the Korean Conflict and during the Vietnam era. According to the 1980 Census, 44,500 American Indians served during World War II, 29,700 during the Korean Conflict, and 73,681 during the Vietnam era. Several sources estimate that an astonishing 23 to 26 percent of all Indians are also veterans. Contributions to the World War I effort were so remarkable in combat and at home that American citizenship was granted to thousands of honorably discharged Indian veterans. The eventual passage in 1924 of an act of Congress to extend citizenship to all Indian people is largely credited with being a direct result of this Indian support of the Nation at war.

In spite of this long history of American Indian participation in our Nation's military conflicts, no major scientific study regarding veterans has identified Indian veterans as a specific group, and no assessment of their particular readjustment needs has ever been conducted. Although Public Law 98–160, the Veterans' Health Care Amendments of 1983, provides for a comprehensive study of the prevalence and incidence in the population of Vietnam veterans of post-traumatic stress disorder and other psychological problems,

American Indian Vietnam veterans are not identified as a specific subgroup as are women, blacks and Hispanic veterans.

In September 1983, several Indian veterans who were working in Veterans' Administration Vet Centers were assembled to establish the National Working Group on American Indian Vietnam Veterans (NWG-AIVV). The purpose of this group was to study Vet Center service delivery to Indian veterans of the Vietnam era, determine if a problem exists, and within agency guidelines develop recommendations which might improve service. Surveys conducted by the NWG-AIVV indicate that some major differences exist between the American Indian Vietnam veteran and his non-Indian counterpart and that the American Indian population itself is diversified. The committee believes these significant differences argue for the need for a separate and extensive study which will display adequate sensitivity to the unique problems and nature of the American Indian population. Studies such as that mandated by P.L. 98-160 cannot adequately evaluate the status and needs of Indian veterans because that study will not take into consideration the unique cultural and social characteristics of the Indian population. It should also be pointed out that the first comprehensive study to evaluate the readjustment of Vietnam era veterans, "Legacies of Vietnam: Comparative Adjustment of Veterans and Their Peers," did not include the American Indian Vietnam veteran in the sample used. Thus, there is in existence today no valid information regarding the particular needs of American Indian veterans.

The committee feels that the Congress and the Veterans' Administration must recognize the contribution made by American Indians during times of war and the effect those wars may have had on them after their return home. The mission of the advisory committee established under H.R. 1538, as amended, would be to examine and evaluate programs and other activities of the Veterans' Administration with regard to the needs of American Indian veterans. In order to accomplish its mission, it is the expectation of the committee that the advisory committee will carefully assess the needs of Indian veterans in the areas of health care, including post-war psychological problems and alcohol and drug abuse, rehabilitation, employment, outreach, and other programs. Further, the advisory committee would evaluate the adequacy of current program administration and structure and make recommendations regarding steps to be taken to ensure maximum service to American Indian veterans. The advisory committee should investigate services provided by other agencies, such as the Indian Health Service and the Bureau of Indian Affairs, with a view to possible interagency agreements or other formal and informal linking mechanisms. Programs in the Department of Labor should also be reviewed for possible coordination and linkage.

Study of female veterans exposed to certain herbicides in Vietnam

The committee bill would direct the Administrator of Veterans' Affairs to provide for the conduct of an epidemiological study of any long-term adverse gender-specific health effects in females that may have resulted from exposure to herbicides containing dioxin while serving in the Republic of Vietnam during the Vietnam conflict.

In February 1984, 90 Members of Congress wrote to the Administrator of Veterans' Affairs expressing their concern that female Vietnam veterans had not been included in epidemiological studies then being conducted by the Centers for Disease Control (CDC) which Congress mandated. In July of this year, during a briefing on CDC's ongoing Agent Orange projects, spokesmen acknowledged the feasibility of such a study. Since that time, the Cabinet Council Agent Orange Working Group has been considering the development of a study on this subject.

Now that a draft protocol on the conduct of the study has been submitted to the Cabinet Council Agent Orange Working Group, the committee strongly believes that the health needs of female Vietnam veterans deserve the same expeditious and careful consideration given to the studies now being conducted for male veterans who served in Vietnam. The original legislation did not limit the study to the male veteran population. Moreover, it is the committee's understanding that the necessary funding for this study can be derived from funds which have already been appropriated for medical research. The VA had requested appropriations in order to fund several studies into the health effects of Agent Orange. One of the studies was later determined to be duplicative of ongoing research into such health effects, so that funds are available for the purposes of this section.

SECTION-BY-SECTION ANALYSIS OF H.R. 1538

Section 1

Subsection (a) would provide that this Act may be cited as the "Veterans' Compensation and Health Care Amendments of 1985".

Subsection (b) would provide that, except as otherwise specifically provided, whenever in this act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

Title I—Compensation Rate Increases

Section 101

Would provide that this part may be cited as the "Veterans' Compensation Rate Amendments of 1985".

Section 102

Would amend present section 314 relating to the rates of service-connected disability compensation.

Subsection (a) would amend subsections (a) through (j) of present section 314 to increase by 3.7 percent the basic monthly rates of compensation paid to veterans with service-connected disabilities rated from 10 to 100 percent. The committee bill would also increase by 3.7 percent:

> The limitations on the total amount payable monthly to a veteran entitled to compensation under subsection (k) who is also entitled to compensation under another subsection of present section 314;

The higher monthly rates of compensation authorized under subsections (l) through (o) and (s) of section 314 for veterans with certain combinations of severe disabilities;

The maximum amount payable monthly to a veteran under subsection (p), which authorizes the Administrator to pay the next higher rate or intermediate rate to a veteran whose disabilities exceed the requirements for any of the rates prescribed in section 314, or who is both blind and deaf;

The rates payable monthly under subsection (r) to veterans who are in need of aid and attendance;

The rate payable under subsection (s) to veterans who are permanently housebound; and

The additional amount payable under subsection (t) to certain veterans who have suffered the service-connected loss or loss of use of an extremity and the non-service-connected loss or loss of use of the other paired extremity.

Subsection (b) would authorize the Administrator to increase by 3.7 percent the rates of disability compensation payable to persons within the purview of section 10 of Public Law 85–857 who are not in receipt of compensation payable pursuant to chapter 11 of title 38. Public Law 85–857 generally codified in title 38 of the United States Code the law relating to veterans' benefits; section 10 of that law provides that any person who was receiving benefits as a veteran on December 31, 1958, under public laws administered by the VA but not so codified, is to continue to receive benefits at the rates payable under such public laws or under corresponding provisions of title 38, whichever is the greater, as long as he or she remains eligible.

Section 103

Would amend paragraph (1) of present section 315 of title 38, relating to additional compensation payable monthly to veterans with service-connected disabilities rated as 30 percent or more disabling who have spouses, children, or dependent parents, to increase those allowances by 3.7 percent. Under paragraph (2) of present section 315, which is not amended by the committee bill, the additional compensation payable for dependents to veterans rated from 30- to 90-percent disabled is prorated, so that, for example, a veteran rated at 30 percent receives 30 percent of the amount specified in paragraph (1) of section 315.

Section 104

Would amend present section 362 of title 38, relating to the clothing allowance payable annually to a veteran receiving compensation whose disability requires the use of a prosthetic or orthopedic appliance or appliances, including a wheelchair, that tends to wear out or tear the veteran's clothing, to increase that allowance by 3.7 percent.

Section 105

Would amend present section 411 of title 38, relating to the rates of dependency and indemnity compensation (DIC) for the surviving spouses of veterans whose deaths are service-connected.

Paragraph (1) would amend subsection (a) of present section 411 to increase by 3.7 percent the DIC benefit payable monthly to the surviving spouse of a veteran who has died as a result of service-connected disability. Under current law, a surviving spouse's DIC is paid according to the pay grade—service rank—of the deceased veteran. The DIC rate payable to the surviving spouses of veterans who had attained the grades of E–1 through O–10 would be increased by 3.7 percent, and proportionate increases would be provided in the rates payable to the surviving spouses of veterans who had served in the positions specified in footnotes 1 and 2 to the table of grades and rates in existing section 411. The enactment of these increases would automatically result in identical increases in the benefits payable at DIC rates under section 410(b) of title 38 to surviving spouses of certain veterans compensated at the 100-percent rate whose deaths were not service connected.

The second footnote of the table of rates in section 411(a) would also be amended to make the DIC rate payable to the surviving spouse of a Coast Guard Commandant commensurate to the DIC rates payable to the surviving spouses of the other military service chiefs, such as the Chief of Staff of the Army. Under current law, the surviving spouses of the other military branches qualify for higher DIC rates than do surviving spouses of Coast Guard Commandants, despite the fact that the underlying pay grades of the persons upon whom entitlement is predicated are not equal by virtue of section 35(a) of Public Law 98–557. Paragraph (1) of section 105 would eliminate the disparity in DIC rates, and restore the historical linkage between DIC rates and the underlying military pay grades of the deceased veterans.

Paragraph (2) would amend subsection (b) of present section 411 to increase by 3.7 percent the dependents' allowance payable for each child under the age of 18 to a surviving spouse receiving DIC.

Paragraph (3) would amend subsection (c) of present section 411 to increase by 3.7 percent the additional amount of DIC payable monthly to a surviving spouse who is a patient in a nursing home or who is helpless or blind or so nearly helpless or blind as to be in need of regular aid and attendance.

Paragraph (4) would amend subsection (d) of present section 411 to increase by 3.7 percent the DIC payable monthly to a surviving spouse who is so disabled as to be permanently housebound.

Section 106

Would amend present section 413 of title 38, relating to DIC for surviving children of veterans whose deaths were service-connected, to provide a 3.7 percent increase in the monthly rates of DIC payable to the veteran's children where no surviving spouse is entitled. Benefits payable at DIC rates under present section 410(b) of title 38 to the surviving children of certain veterans compensated at the 100-percent rate whose deaths were not service-connected would also be automatically increased as a result of this increase under section 413.

Section 107

Would amend present section 414 of title 38, relating to supplemental DIC for certain surviving children.

Paragraph (1) would amend subsection (a) of present section 414 to provide a 3.7 percent increase in the additional allowance payable monthly to a child eligible for DIC who has attained the age of 18 and who became permanently incapable of self-support before reaching the age of 18.

Paragraph (2) would amend subsection (b) of present section 414 to provide a 3.7 percent increase in the DIC payable monthly, concurrently with the payment of DIC to a surviving spouse, to a surviving child who has attained the age of 18 and who became permanently incapable of self-support before reaching the age of 18.

Paragraph (3) would amend subsection (c) of present section 414 to provide a 3.7 percent increase in the additional DIC payable monthly, concurrently with the payment of DIC to a surviving spouse, to a surviving child pursuing a course of education approved under present section 104 of title 38.

Section 108

Would provide that the amendments made by this title shall take effect on December 1, 1985.

Title II—Health Care Eligibility Reform

Section 201

Would provide that this part may be cited as the "Veterans' Health-Care Eligibility Reform Act of 1985".

Section 202

Would amend various sections of chapter 17 of title 38, relating to eligibility for health-care services from the Veterans' Administration.

Subsection (a) of Section 202 would amend section 610 of title 38, United States Code.

Paragraph (1) of subsection (a) would revise section 610(a) to require the Administrator to furnish hospital care which the Administrator determines is needed to eight categories of veterans:

(1) to any veteran for a service-connected disability;

(2) to a veteran discharged for a disability incurred or aggravated in line of duty;

(3) to a veteran entitled to receive disability compensation;

(4) to a veteran disabled by treatment or vocational rehabilitation;

(5) to certain veterans exposed to ionizing radiation or to dioxin;

(6) to former prisoners of war;

(7) to veterans of the Spanish-American War, Mexican border period, or World War I; and

(8) to veterans who are unable to defray the expenses of necessary care (as defined in section 622).

The limitation on furnishing hospital care "within the limits of Veterans' Administration facilities" would be made inapplicable to these eight categories of eligible veterans. A ninth category of veterans seeking hospital care for treatment of a non-service-connected disability would be eligible for such care only if they agreed to make a copayment in an amount discussed below. Such care could

only be provided within the limits of VA facilities. Under existing subdivision (6) of section 610(a), a separate basis of eligibility for veterans sixty-five years of age or older is set forth; this subdivision would be eliminated by the proposed revision. The Administrator would continue to furnish nursing home care on a discretionary basis within the limits of VA facilities.

Paragraph (2) of subsection (a) would make conforming amendments to section 610(e).

Paragraph (3) of *subsection (a)* would add two new subsections to section 610. The proposed subsection (f) describes the amount of, and conditions under which, a copayment or deductible would be paid by veterans who do not fall into one of the categories proposed to be codified at section 610(a)(1)-(8). Prior to receiving needed care, a veteran who did not fall into one of these categories would be required to agree to pay a deductible. For inpatient or nursing home care, the copayment would be equal to the lesser of the cost of care or the inpatient hospital deductible required of persons who are eligible for Medicare.

Under the proposed subsection (f)(2), a veteran would not be required to pay the inpatient deductible more than once in any twelve month period. The proposed subsection (f)(3) provides that amounts collected from veterans would be deposited in the Treasury as proprietary receipts. As defined in the proposed subsection (f)(4), the inpatient Medicare deductible does not include the Medicare coinsurance requirement applicable to hospital stays of more than 60 days.

The proposed subsection (g) would clarify that the provision of services required to be furnished under section 610 is subject to the limitations on such services found in the definition of "Veterans' Administration facility" in section 601 of title 38. It would also clarify that nothing in section 610 requires the Administrator to furnish care to a veteran to whom another government agency has a duty to provide care in an institution of such government, and that the Administrator retains the discretion to determine the appropriateness and manner in which medical services, therapies, or programs are furnished under chapter 17 of title 38.

Subsection (b) of section 202 would amend the provisions of section 612 of title 38, which deal with eligibility for care on an outpatient basis. The provision of outpatient services to veterans described in proposed subsections (a), (f)(1), and (g) would be made mandatory under the reported bill. Under the proposed subsection (f)(3)(A), an eligible veteran who is able to defray the cost of necessary care would be required to agree to make a payment for each visit equal to 20% of the estimated average cost of an outpatient visit. The copayment would not be applicable to outpatient services provided in order to complete treatment incident to care in a VA hospital. The proposed subsection (f)(3)(C) would cap the amount of the copayment payable by a veteran in any twelve month period for both inpatient and outpatient services at the amount of the inpatient Medicare deductible, discussed above.

Paragraph (3) of section 202(b) would repeal subsection (i) of section 612.

Paragraph (4) of section 202(b) would make clarifying amendments to subsection (j) of section 612.

Subsection (c) of section 202 would add a new subsection to section 622 of title 38, United States Code, which deals with evidence of an individual's inability to defray the cost of necessary medical care. Section 622 presently provides that veterans who meet the eligibility criteria for Medicaid, VA pension, or who have a service-connected disability are presumed to be unable to defray the cost of necessary medical care. A new category of presumptive eligibles would be added by the proposed subsection (b). Under the proposed subsection, a veteran would be eligible for necessary medical care under the "unable to defray" category (recodified as section 610(a)(8)) if his or her family's income was equal to or less than 3.34 times the maximum annual rate of pension payable to totally disabled veterans under chapter 15 of title 38. This amount is referred to the health-care income threshold.

The substance of the rule set out in section 522 pertaining to pension net worth limitations is restated as proposed paragraph 2 of section 622(b). It provides that if a veteran or his immediate family have sufficient assets (referred to as the "corpus of the estate") which, under all the circumstances, could reasonably be expected to be consumed in order to provide for the veteran's maintenance, then the Administrator may refuse to determine that the veteran is unable to defray necessary medical expenses. Under the proposed subsection (b)(3), in determining a veteran's annual family income, the Administrator would consider the same items and sources of income and would allow the same exclusions allowed in the pension program as set forth in chapter 15 of title 38.

Section 202(d)

Would make conforming amendments to sections which contain references to the provisions amended by section 1022(a)–(c).

Section 202(e)

Would provide that the provisions of this bill would apply to hospital care, nursing home care and medical services furnished after the end of the 60 day period beginning on the date of enactment of the proposed bill. However, a veteran who is in an inpatient or outpatient status on the day before the effective date would not be affected by the revised eligibility or deductible provisions for care furnished in connection with the same spell of illness for which treatment was furnished prior to the effective date.

Section 202(f)

Would provide that the amendments made by section 202 shall expire on October 1, 1988.

Section 203

Would revise section 629 of title 38, United States Code, which deals with the right of the United States to recover the cost of certain medical care and services from third parties.

The proposed section 629(a) restates the existing provisions of section 629(a) without substantive modification except for the addition of an additional condition under which the United States may seek recovery. Both the existing and proposed section 629 apply only to care and services for non-service-connected disabilities. The

new condition is for care provided to a veteran with no service-connected disability who is entitled to care or reimbursement for care under an insurance policy or other contract or arrangement for reimbursing expenses for health services. This authority would be in addition to the Administrator's existing authority to collect under workers' compensation laws, automobile "no-fault" insurance policies, and "victims of crime" compensation funds.

Proposed subsection (b) is a restatement of existing subsection (c) of section 629.

Under proposed subsection (c), the Administrator would be authorized to waive, settle, or compromise any claim of the United States pursuant to this section.

Proposed subsection (d)(1) is patterned after section 3718 of title 31. It provides that the Administrator may enter into a contract with a collection service that retains a portion of the amount collected as a fee for its services. The organization would be subject to the Privacy Act of 1974, 5 U.S.C. § 552a, the Fair Debt Collection Practices Act, 15 U.S.C. § 1692 *et seq.*, and other Federal and State laws related to debt collection practices. The Administrator would retain the authority to resolve a dispute, compromise a claim, and collection action, and refer a matter to the Attorney General.

Paragraph (2) of this subsection restates the provisions of section 629(b) pertaining to the amount which the Administrator may recover. The amount recoverable may not exceed the lesser of the reasonable cost of care and services or the maximum amount specified by the law of the state or political subdivision concerned or by any contractual provision to which the veteran is subject. The Administrator would also be authorized to contract with health insurance carriers or other contractors to assist in determining or establishing reasonable costs.

Subsection (e) is a restatement of existing subsection (d).

Subsection (f) is patterned after the existing language of subsection (e). It would effectively nullify any contract provision agreed to after the date of enactment of this measure which seeks to bar the United States from recovery in connection with care furnished in the circumstances described in subsection (a) of section 629. The prohibition is worded so that it would operate prospectively without impairing contractural arrangements which are not described in this subsection.

Subsection (g) provides that amounts collected on behalf of the United States under this section shall be deposited in the Treasury as proprietary receipts.

Subsection (h) provides that third parties and the insured may have access to clinical records of a veteran beneficiary for the sole purpose of verifying that services which are billed were in fact furnished.

Subsection (i) defines the term third party to mean a State or political subdivision of a State, an employer, an employer's insurance carrier, an automobile accident reparation insurance carrier, (terms used in the existing section 629), insurance medical service, or health plan carrier, or contractor. This definition specifically excludes Medicare or Medicaid (or similar State plans under title XVIII of the Social Security Act) from this section's coverage; therefore, recovery may not be sought for care where the source of

reimbursement is Medicare or Medicaid. Section 202(b) provides that this section will be applicable to care and services provided on and after the date of enactment, but it would not affect agreements that were entered into before the date of enactment. However, a modification or renewal of the policy subsequent to the date of enactment would have the effect of making the policy subject to this section.

Section 204

Would add a new section to chapter 17 of title 38, United States Code. The proposed section 625 would require non-federal providers of hospital services to Medicare beneficiaries to accept Veterans' Administration beneficiaries on a similar basis. It would also require such providers to accept payments made by the Administrator in accordance with VA regulations as payments in full. In the event that a provider did not comply with these requirements, the Administrator could initiate compliance proceedings through the Secretary of Health and Human Services.

Section 205

Would require the Administrator to report to the Committees on Veterans' Affairs on the number of veterans who receive health care over a one-year period, the number who applied for but did not receive such care, and the reasons why such veterans did not receive the care which they sought. The report would cover a one year period beginning on the effective date of the amendments made by section 202, and would be due 30 days after the end of the one year period.

Title III—Miscellaneous

Section 301

Subsection (a) would require the Administrator to establish, by no later than November 1, 1985, an advisory committee to be known as the Advisory Committee on American Indian Veterans (hereinafter referred to as the Committee).

Subsection (b) would authorize the Committee to examine and evaluate the furnishing of VA services to American Indian veterans, including an assessment of the specific needs of such veterans and the manner in which VA programs and activities meet those needs.

Subsection (c) would establish the membership of the Committee, to include:

The Secretary of Labor, or a representative of the Secretary of Labor designated by the Secretary after consultation with the Assistant Secretary of Labor for Veterans' Employment;

The Chief Medical Director and Chief Benefits Director of the VA; and

Members appointed by the Administrator from the general public, including representatives of American Indian veterans, American Indian veterans with service-connected disabilities, and persons who are recognized authorities in fields pertinent to the needs (such as health care needs and the delivery of health care services by VA) of those veterans.

Subsection (d) would authorize the Administrator to invite representatives of other departments and agencies of the Federal Government to participate in the meetings and activities of the Committee.

Subsection (e) would direct the payment to the members of the Committee for reasonable and necessary expenses, as determined by the Administrator, incurred in carrying out Committee duties.

Subsection (f) would require the filing of certain reports respecting the matters described in subsection (b) of section 301.

Paragraph (1) of subsection (f) would require the Committee to transmit to the Administrator, not later than November 1, 1986, a report on such matters that were examined and evaluated during fiscal year 1986. Additionally, it would require the Committee to transmit to the Administrator, not later than November 1, 1987, a report on such matters that were examined and evaluated during fiscal year 1987.

Paragraph (2) of subsection (f) would require the Administrator, within 60 days after receiving each report, to transmit to Congress a copy of such report together with any appropriate comments.

Subsection (g) of section 301 would provide that the Committee shall terminate on the date on which the second report is transmitted by the Committee pursuant to paragraph (1) of subsection (f).

Section 302

Would provide for an epidemiological study of any long-term, gender-specific adverse health effects in female veterans of exposure to phenoxy herbicides and the contaminant dioxin during service in the Republic of Vietnam.

Subsection (a) would require the Administrator to conduct such a study, and provides authority to expand the scope of the study.

Paragraph (1) of subsection (a) would require the Administrator to conduct an epidemiological study of any long-term adverse gender-specific health effects in female veterans who served in the Republic of Vietnam during the Vietnam conflict that may result from exposure to phenoxy herbicides (including Agent Orange) and dioxins produced during the manufacture of such herbicides.

Paragraph (2) of subsection (a) would authorize the Administrator to expand the scope of the study to include evaluation of long-term adverse gender-specific health effects in female veterans of such service that may result from other service-related factors, including exposure to other herbicides, chemicals, medications, or environmental hazards or conditions.

Paragraph (3) of subsection (a) would authorize the Administrator to also evaluate the means of detecting and treating adverse gender-specific health effects found through the study.

Paragraph (4) of subsection (a) would provide for the study to be conducted through contracts or agreements with public or private agencies or persons.

Subsection (b) would provide for establishing, monitoring, and reporting on a study protocol.

Paragraph (1) of subsection (b) would require the study to be conducted in accordance with a protocol approved by the Director of the Office of Technology Assessment (hereinafter referred to as the Director).

Paragraph (2) of subsection (b) would require the Director to monitor the study to ensure compliance with such protocol.

Paragraph (3) of subsection (b) would require the Director to submit to the appropriate committees of Congress a report explaining the basis of the Director's approval or disapproval of the protocol and providing the Director's conclusions regarding the scientific validity and objectivity of the protocol. Paragraph 3 would also require the Director, in the event a protocol has not been approved within 180 days following enactment of this Act, to submit to the appropriate congressional committees a report describing the reasons for such delay in approval and an updated report each 60 days thereafter until a protocol is approved.

Paragraph (4) of subsection (b) would require the Director to submit to the appropriate committees of Congress, at times specified in paragraph (4), reports on the conduct of the study as monitored by the Director. Such reports are to be submitted at the following times:

(A) before the end of the 6-month period beginning on the date of the approval of the protocol by the Director;

(B) before the end of the 12-month period beginning on such date; and

(C) annually thereafter until the study is completed or terminated.

Subsection (c) would provide for the continuation of such study for as long after the submission of the first report under paragraph (d)(1) as the Administrator may determine reasonable.

Subsection (d) would require the Administrator, in accordance with a specific timetable, to submit annual reports to the appropriate committees of Congress and publish in the Federal Register any proposed actions respecting VA programs.

Paragraph (1) of subsection (d) would require the Administrator to submit to appropriate congressional committees, not later than 24 months following the date of approval of the protocol and annually thereafter, a report containing a description of the study results up to that point, as well as such comments and recommendations for administrative or legislative action as the Administrator considers appropriate.

Paragraph (2) of subsection (d) would require the Administrator to publish in the Federal Register, not later than 90 days after the submission of each report described in paragraph (d)(1), an explanation of any action that the Administrator proposes to take respecting VA programs.

Paragraph (3) of subsection (d) would provide for the expiration of the reporting requirement contained in paragraph (d)(1) upon the submission of a report after the completion of the epidemiological study.

Subsection (e) would reconcile this section with the Budget Act. Paragraph (1) of subsection (e) would defer the authorization of new budget authority prior to fiscal year 1987, and paragraph (2) would permit entering into contract under subsection 302(a) only where the necessary appropriated funds are available or where the Government's obligations under contract are expressly conditioned upon the availability of sufficient appropriated funds.

Subsection (f) would define the term "gender-specific health effects in females," for the purposes of this section, to include effects on female reproductive capacity, reproductive organs, reproductive outcomes, female-specific organs and tissues, and other effects unique to the physiology of females.

COMMITTEE COST ESTIMATE

On September 30, 1985, the Congressional Budget Office provided the committee with a cost estimate of the committee legislation.

The committee generally accepts the cost estimate of the Congressional Budget Office. However, the committee is not in agreement with the CBO estimate on the administrative cost involved with the implementation and operation of that provision of the bill requiring veterans with family income above $25,000 to pay a deductible. According to CBO, the cost would be about $20 million in fiscal year 1986.

According to the Veterans Administration, the administrative cost of this provision would be only $3.6 million. The committee is more in agreement with the VA estimate and has assumed a cost of $10 million, a figure somewhere between the two estimates. In addition, the committee has been advised by the Veterans' Administration that implementation of the provision which would set a ceiling on contract hospital care reimbursement rates at the rate payable under Medicare would save approximately $6 million in fiscal year 1986.

The committee believes the enactment of the reported bill will meet the mandate of the House and Senate for Function 700 savings. It is the committee's view that subject to the revisions noted above to the CBO cost estimate, H.R. 1538, as amended, will produce savings as follows: $301 million in budget authority and $297 in outlays in FY 1986; $505 million in budget authority and outlays in FY 1987; and $561 million in budget authority and outlays in FY 1988. The total for the three fiscal years in $1.367 billion in budget authority and $1.363 billion in outlays.

The Congressional Budget Office estimate is as follows:

CBO COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 30, 1985.

Hon. G.V. MONTGOMERY,
Chairman, Committee on Veterans' Affairs, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: In response to your request, CBO has prepared the revised cost estimate for H.R. 1538, the Veterans' Compensation and Health Care Amendments of 1985, as ordered reported by the House Committee on Veterans' Affairs, September 11, 1985.

The estimate of H.R. 1538 sent to you on September 13 reflected our understanding that the means test established under Title II would be permanently authorized. We were informed by Committee staff this morning that the means test would only be authorized

as a three-year pilot project. The cost estimate has been revised accordingly.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

With best wishes,

Sincerely,

RUDOLPH G. PENNER.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 1538.

2. Bill title: Veterans' Compensation and Health Care Amendments of 1985.

3. Bill status: As ordered reported by the House Committee on Veterans' Affairs, September 11, 1985.

4. Bill purpose: To increase by 3.7 percent the monthly benefits paid under the disability compensation and the Dependency and Indemnity Compensation programs; to require copayments of certain veterans seeking health care from the Veterans Administration (VA); to require reimbursement by third-party health insurers of the cost of care provided by the VA to insured veterans without service-connected disabilities; and for other purposes.

5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Function 700:					
Budget authority	69	−78	−143	−100	−160
Outlays	31	−75	−140	−97	−158
Function 570:					
Budget authority	2	3	3	0	0
Outlays	5	8	9	0	0
Net budgetary impact:					
Budget authority	71	−75	−140	−100	−160
Outlays	36	−67	−131	−97	−158

The effects of this bill would fall in budget functions 700 and 570.

Basis for estimate: This estimate assumes an enactment date of October 1, 1985. If enactment of the bill should occur after this date, the budgetary impact in fiscal year 1986 could be significantly different from that shown above.

The following section-by-section cost analysis only addresses those sections of the bill that could be expected to have a significant budgetary impact.

Title I.—This title would increase by 3.7 percent the monthly rates payable under the disability compensation and the Dependency and Indemnity Compensation (DIC) programs. The increase would be effective on December 1, 1985.

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Budget authority	311	366	358	349	340
Outlays	280	367	359	350	341

The cost of this title was estimated by multiplying the average costs in each year for all disability compensation cases and for all DIC cases by 3.7 percent. The resulting average increases in costs per year were then multiplied by the estimated number of cases in each program each year to calculate the annual cost. Future average cost and caseload levels were projected according to historical trends for veterans and survivors by periods of service.

The baseline for the First Concurrent Resolution on the Budget for Fiscal Year 1986 assumes a cost-of-living adjustment in compensation rates of 4.1 percent. This provision, by increasing compensation rates by only 3.7 percent, would reduce spending in the compensation program below the levels assumed in the budget resolution by the following amounts:

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Budget authority	−34	−40	−39	−38	−37
Outlays	−30	−40	−39	−38	−37

Title II.—Section 202. This section would establish as a three-year pilot program a health-care income threshold equal to applicable income ceiling for VA pension multiplied by 3.34. All veterans with incomes below this amount and certain categories of veterans without regard to income would be considered eligible for hospital and ambulatory care in VA facilities without restriction. Veterans seeking hospital care whose incomes are above this amount would be provided care on a space available basis and would be required to pay a deductible equal to the deductible charged by Medicare. For outpatient care, veterans with restricted eligibility would be required to pay an amount equal to 20 percent of the average cost of an outpatient visit, but in no event would the total payments of a veteran in any given year exceed the amount of the Medicare deductible.

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Function 700:					
Budget authority	−48	−91	−99	0	0
Outlays	−48	−91	−99	0	0
Function 570:					
Budget authority	2	3	3	0	0
Outlays	5	8	9	0	0

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Net budgetary impact:					
Budget authority	−46	−88	−96	0	0
Outlays	−43	−83	−90	0	0

This estimate was derived through the use of a computer model that is based on a projection of total discharges expected from all VA hospitals in future years under current law. This projection was derived by multiplying age-specific projections of the veteran population by estimated use rates. (See Congressional Budget Office, *Veterans Administration Health Care: Planning for Future Years*, April 1984.) The model reduces the anticipated number of discharges by the percent estimated in each year who would qualify for unrestricted eligibility to health care under the bill and, thus, would not be subject to the means test.

Of the population subject to the means test, the model calculates the number who would exceed the income limit based on income distribution data from the *1979 National Survey of Veterans* conducted by the VA. It is assumed that 5.0 percent of those who would be required to pay copayments would choose to receive their care elsewhere. The remaining number of discharges was then multiplied by the projected Medicare deductible amount to determine the estimate amount of copayment collections. The number of discharges estimated to choose alternative care was multiplied by the projected average cost per patient treated to calculate the savings in this category. A similar process was used to estimate the copayment collections and the savings from those leaving the outpatient care system.

Based on data from the *Survey of Aging Veterans* (Lou Harris and Associates, 1983), it was estimated that in 1986 23 percent of the veterans who would choose to seek their health care outside of the VA rather than pay the required deductible would have Medicare Hospital Insurance and 21 percent would have Supplentary Medical Insurance. The shifting of these few cases from VA hospitals to Medicare-covered stays in private or community hospitals would result in the small offsetting cost in budget function 570 shown above.

This estimate assumes that the interview and paperwork required to evaluate a prospective patient with restricted eligibility would take one hour, on the average, and would be performed by a GS–7 employee. The assumed grade level is based on information from the VA. An average cost of billing and collecting inpatient deductibles of $30 per bill was used on data from the General Accounting Office (GAO) study, *Legislation to Authorize VA Recoveries from Private Health Insurance Would Result in Substantial Savings* (GAO/HRD–85–24, Feb. 1985). This average cost was reduced to $20 per bill in the cases of copayment billings for outpatient care, however. Because the average copayment for outpatient care would be far less than for inpatient care, it is expected that collection efforts would be considerably less extensive for these bills.

Several important assumptions were made in the development of this estimate. We assumed that the VA could implement the means test and copayment provisions fully within 90 days of enactment of the legislation. This assumption is based on statements to that effect contained in a letter, dated July 16, 1985, from John Ditzler, M.D., Chief Medical Director of the VA, to Mack Fleming, Chief Counsel and Staff Director of the House Veterans' Affairs Committee. Should significantly more time be required to implement the legislation, the fiscal year 1986 savings could fall considerably below the level estimated above.

We have further assumed that this bill would not result in a significant increase in the use of contract care by the VA to provide care outside of the VA system. In an analysis of this legislation, the legal staff of the House Committee on the Budget has concluded that, based upon House precedents and interpretations of the Congressional Budget Act, this bill does not appear to establish an entitlement to health care for any category of veterans under the definition of an entitlement contained in section 401(c)2(C) of the Congressional Budget Act of 1974. Since the bill states that "Nothing in this section requires the Administrator to furnish hospital care in a facility other than a Veterans Administration facility; . . .", it was assumed that veterans with unrestricted eligibility to care would only be eligible for care to the extent that resources were available within the VA system.

This estimate does not reflect the possibility that some additional demand for care could be induced by changes in the eligibility provisions of the bill or by the replacement of the poverty oath with a specific means test. This effect could not be included because the size and likelihood of the induced demand would be heavily dependent on the amount of publicity given to the changes by the VA and by veterans service organizations. This cannot be predicted with any certainty. Also, there is no data on which to base an estimate of the effect these amendments would have on the demand for care, even if the changes were highly publicized. The size of such induced demand is not expected to be large. Nevertheless, any additional demands for care resulting from these provisions would reduce the savings generated by the bill.

Section 203. This section would authorize the VA to recover from third-party health insurers the cost of medical care provided to insured veterans who have no service-connected disabilities.

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Budget authority	−203	−354	−403	−449	−500
Outlays	−203	−354	−403	−449	−500

Based on the GAO study of third-party reimbursement (GAO/HRD-85-24, Feb. 1985), it was assumed that 18.4 percent of the episodes of medical and surgical care in VA hospitals and 10.8 percent of episodes of psychiatric care would be provided to veterans with valid health insurance. Also based on this study, it was assumed that 85 percent, on the average, of the cost of care would be reim-

bursed by the insurer. An average cost for billing and collection activities of $30 per bill was used.

A factor not considered in this estimate is the possibility that the health insurers would fight the constitutionality of this legislation in the courts. In a 1979 review of a similar provision, S. 759, the Department of Justice concluded that there would be no constitutional bar to such legislation. Some delay in the receipt of recoveries would be expected, however, if the insurers choose to take the issue to the courts.

Section 204. This section would require that non-federal providers of medical care who receive payments from Medicare based on diagnosis-related-group (DRG) payment schedules accept similar payment policies by the VA when contracted by the VA to provide care to veterans.

The VA is in the process of converting their procedures for reimbursing non-federal hospitals for contract care of veteran patients to a DRG reimbursement schedule. This provision would require that a non-federal facility accept the DRG reimbursement for a VA patient if such reimbursements are accepted for Medicare patients. We have estimated that this provision would have no significant budgetary impact, because we assume that, in the absence of the amendment, the VA would discontinue to contract with any facility that refused to accept DRG-based payments. The number of facilities refusing such payments should be quite small since the hospitals in question are already accustomed to accepting DRG reimbursements for Medicare patients.

Section 205. This section would require the VA to submit a report to the House and Senate Committees on Veterans' Affairs detailing the number of veterans receiving care under the provisions of this title, the number applying for but not receiving care, and the reasons for care being provided.

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Estimated authorization level	1	1	1	0	0
Estimated outlays	1	1	1	0	0

This estimate is based on information from the VA, which states that the data required by the report on veterans applying for but not receiving care would require approximately one hour per workday per VA medical facility. The salary and benefit cost of the labor involved would be about $9 an hour in 1986. This cost was inflated in the outyears for anticipated increases in federal pay.

Title III.—Section 302. This section would require the VA to conduct a study of the gender-specific health effects in females of military service in the Republic of Vietnam.

[By fiscal years, in millions of dollars]

	1986	1987	1988	1989	1990
Estimated authorization level	8	0	0	0	0
Outlays	1	2	2	2	1

This estimate is based on information from the Center for Disease Control (CDC), which has already prepared a preliminary protocol for the required study. The CDC estimates that the study would take between three and four years to complete, once the final study protocol was approved, at a total estimated cost of $8.3 million.

6. Estimated cost to state and local governments: The Congressional Budget Office has determined that the budgets of state and local governments would not be directly affected by enactment of this bill.

7. Estimate comparison: None.

8. Previous CBO estimate: On July 19, 1985, CBO submitted to the House Committee on Veterans' Affairs an estimate of H.R. 1538 as introduced in the House of Representatives on March 19, 1985. That version of the bill contained a 4.1 percent increase in VA compensation rates. No other provisions were included. Since the version of the bill ordered reported on September 11, 1985 differs from the introduced version in every respect, the two cost estimates should not be compared.

On September 10, 1985, CBO submitted a cost estimate of a draft version of Title II of H.R. 1538. Certain sections contained in the reported version of title were not included in the draft version. For this reason the estimates of the two versions of Title II differ slightly.

In addition, the earlier cost estimate stated that certain categories of veterans would be granted an entitlement to VA health care by the provisions of Title II. This statement was based on information from the Committee staff regarding the Committee's intent. However, based on a subsequent review of the legislation for possible Budget Act violations, the legal staff of the House Committee on the Budget concluded that the language of the bill does not appear to create an entitlement as defined by the Congressional Budget Act of 1974, because no payments would be required to be made by the government to any individual or government entity.

On September 12, 1985, CBO submitted an estimate of H.R. 1538 as reported on September 11. Based on information from Committee staff, that estimate reflected the assumption that the means test would be permanently authorized. Since that time, the bill has been amended to provide that the means test would operate for only three years as a pilot program.

9. Estimate prepared by: K.W. Shephard.

10. Estimate Approved by: G.G. Nuckols for James L. Blum, Assistant Director for Budget Analysis.

Oversight Findings

No oversight findings have been submitted to the Committee by the Committee on Government Operations.

Inflationary Impact Statement

The enactment of the reported bill would have no inflationary impact.

Agency Report

The Committee received the following views of the Veterans' Administration on provisions contained in the reported bill:

Veterans' Administration,
Office of the Administrator of Veterans' Affairs,
Washington DC, March 19, 1985.

Hon. Thomas P. O'Neill, Jr.,
Speaker, House of Representatives,
Washington, DC.

Dear Mr. Speaker: I am pleased to submit a draft bill to increase the statutory rates of disability compensation for veterans and rates of dependency and indeminity compensation for surviving spouses and children of veterans, and for other purposes. I respectfully request that it be referred to the appropriate committee and enacted promptly.

Title I would authorize the increased rates of disability compensation and dependency and indemnity compensation. The disability compensation program is designed to provide monetary relief from impairments in earning capacity suffered by veterans disabled during, or as a result of, military service. Rates of compensation vary with the degrees of disability demonstrated, and additional compensation is payable for dependents if the veteran's disability is rated 30 percent or more disabling.

Dependency and indeminity compensation (DIC) benefits are payable under chapter 13 of title 38 to the surviving spouses and children of veterans whose deaths were service-connected. Payments at DIC rates may also be made if a veteran's death was not service-connected but the veteran was rated as totally disabiled for a specified period prior to death. Surviving spouses' DIC rates are based on the veterans' military pay grades. A surviving spouse may receive additional payments for the veteran's children under the age of eighteen, or if the surviving spouse is disabled. Children over the age of eighteen who become helpless before reaching that age may receive DIC, as can those age eighteen to twenty-three attending approved educational institutions. If there is no surviving spouse, a child under the age of eighteen may also receive DIC in the child's own right.

The administration of the disability compensation and DIC programs is one of the VA's most important missions. We recognize a duty to recommend periodic adjustments in monthly rates as economic conditions change.

In recent years, compensation adjustments have been keyed to indexed cost-of-living increases in Social Security and VA pensions.

The current projection is for 4.1 percent increase in Social Security rates when they are adjusted in December 1985. Accordingly, we recommend a corresponding increase of 4.1 percent in the rates of disability compensation and DIC, effective December 1, 1985.

Section 101 of the draft bill would increase rates of disability compensation, including the so-called special monthly compensation rates (except for the "K" rate), by approximately 4.1 percent. As with all rates in our proposal, odd amounts resulting from our computations were rounded down to the nearest dollar.

Sections 102 and 103, respectively, would provide for an approximate 4.1 percent increase in rates of additional compensation for dependents, and in the clothing allowance payable under section 362 of title 38 to certain veterans wearing or using prosthetic or orthopedic appliances.

Sections 104 through 106 would increase DIC rates by approximately 4.1 percent, effective December 1, 1985.

Our five-year estimate of the cost of the enactment of the proposed increases under title I, based on a 4.1 percent rate adjustment, is as follows:

[In millions of dollars]

Fiscal year:	*Cost*
1986	$342.8
1987	411.8
1988	412.7
1989	412.4
1990	412.4

Title II contains four proposals to improve veterans' benefits programs by amending eligibility requirements. Section 201 would change the effective date for a reduction or discontinuance of benefits that are based upon school attendance of a payee or payee's dependent. Under current law, reductions occur as of the last day of the month in which the school attendance is discontinued. Under our proposal, the effective date for reduction or discontinuance would be the day following the last date of attendance, based upon section 3012(a) of title 38.

This change would conform to current rules for discontinuing benefits used upon a child's attainment of age eighteen and terminating benefits for, or on behalf of, a child as of its eighteenth birthday. We believe there is no substantial difference between terminating based upon a child's attainment of age eighteen and terminating benefits for an adult student between the ages of eighteen and twenty-three who discontinues his or her attendance.

We estimate enactment of this proposal would result in benefit savings of less than $1 million and administrative costs amounting to less than $100,000 in any fiscal year.

Section 202 would amend section 101(22) of title 38, relating to the definition of "active duty for training," in order to permit the full-time operational duty performed by National Guard and Air National Guard members to be considered "active duty" for title 38 purposes. Under section 101(21)(A) of title 38, active duty means full-time duty in the armed forces other than active duty for training. Under section 101(22)(C), active duty for training, with respect to guard members, means full-time duty authorized under title 32, regardless of whether the duty is perfomed for operational or train-

ing purposes. This amendment would limit "active duty for training" performed by guard personnel to full-time duty performed for training purposes.

In recent years, guard members called to full-time operational duty (usually to serve as instructors or recruiters) have been assigned active guard and reserve (AGR) status if the duty period is 180 days or more, and active duty support (ADS) status if the duty period is 179 days or less. These designations have led to some confusion on the part of guard members as to their eligibility for title 38 benefits. Although a guard member on AGR or ADS status who is disabled in the line of duty would be eligible for VA compensation, "active duty for training" is not qualifying for certain other title 38 benefits, primarily home loan guaranty benefits and health care on a non-service-connected basis.

Generally, loan guaranty eligibility requires 181 days of continuous active duty, either for service personnel or peacetime veterans. The amendment made by this section would, therefore, assist guard members in AGR and ADS status to qualify for benefits on the same basis as other active-duty service members and peacetime veterans. Our amendment would be effective with respect to duty performed after September 30, 1985; however, guard members in AGR or ADS status as of the date of enactment would be able to include their days of service prior to that date in qualifying for loan guaranty benefits.

We estimate enactment of this proposal would result in benefit costs of less than $1 million in any fiscal year, and VA would incur less than $100,000 in administrative costs.

Recognition of a child as the legally adopted child of a veteran under current law may give rise to additional benefits, including increased compensation or pension payments to the adopting veteran, and dependency and indemnity compensation and educational benefit entitlement for the child. Our proposed section 203 would amend criteria for recognition of foreign adoptions, which are set forth in section 101(4)(B) of title 38. Specifically, the proposal would provide that an adoptee could not be considered the legally adopted child of a veteran for the purposes of benefits eligibility under title 38 unless the adoption occurred prior to the date any entitlement of the veteran to disability compensation or pension arose. The amendment would apply only to an adoption under the laws of a jurisdiction other than a state, territory, possession of the United States, the District of Columbia, Puerto Rico, or the Northern Mariana Islands, and only where the adoptee resides in a foreign jurisdiction.

Our proposal is designed to address a longstanding problem concerning recognition of adoption decrees issued under the laws of foreign jurisdictions. Foreign courts in some cases grant adoptions without observance of standards comparable to those applied in courts of this country. In a number of instances, foreign courts have permitted aged, infirm veterans to adopt young relatives over whom they have no intention of assuming a true parental relationship. The sole motivation for these adoptions appears to be a desire to obtain increased veterans' benefits or to assure benefits entitlement for the adoptee upon the veteran's death.

The high value of United States veterans' benefits in some foreign economies creates a substantial incentive for contrived adoptions. For example, in the Philippines, the additional pension payable to a veteran for an adopted child is reported to be comparable to the salary of a rural schoolteacher. Adoption of a child will in many cases result in a substantial economic gain to a veteran residing abroad. While economic conditions in the Philippines and the large number of veterans residing there make that country a primary source of concern, the VA has received claims based on questionable adoptions granted in other foreign jurisdictions.

In recognition of the threat to the integrity of the veterans' benefit programs posed by contrived adoptions, Congress in 1979 enacted standards for recognition of foreign adoptions. Section 401 of Public Law No. 96-22, 93 Stat. 47 (1979), added a new section 101(4)(B) to U.S. Code title 38 providing that a person residing outside the United States adopted under the laws of a foreign jurisdiction shall not be considered the legally adopted child of a veteran unless stated criteria relating to age at the time of adoption, support from the veteran, residence with the veteran, and absence of custody by a natural parent, are met. In the case of a deceased veteran, the adopted child must have met the requirements for at least one year prior to the veteran's death or the veteran must have received benefits for the child during the year preceding death.

Although the 1979 amendment has been of considerable benefit in combating adoption abuses, experience with the statute has revealed significant difficulties in administration, particularly in applying custody and residence criteria. We know of at least two claims in which the VA has recognized foreign adoptions under the amended statute where the motivation for the adoption must be considered suspect. Both claims involved the adoption of children by aged grandparents in receipt of veterans' pension benefits. In neither case did the adoption appear to serve any purpose other than generation of additional pension entitlement, and in both cases natural parents remained in close proximity to the adopted children and continued personal contact with them.

Even where the adoption criteria can be applied to bar questionable claims, the criteria have proven burdensome to administer. Development of evidence in foreign adoption claims is difficult, and adjudication of these claims is often complex and time-consuming.

The proposed amendment would greatly reduce the potential for abuse and simplify claim development by permitting recognition of a foreign adoption only if the adoption took place before the veteran's benefit entitlement arose. Where this standard is met, existing criteria would serve as a further safeguard against contrived claims. In this way, the proposed amendment would further Congress' objective, in enacting Public Law No. 96-22, to preclude entitlement based on adoptions entered for the sole purpose of securing veterans' benefits.

A comparable provision has been in force in Social Security old-age and disability insurance programs for a number of years. Under section 402(d)(8)(D) of U.S. Code title 42, a child adopted after an individual becomes entitled to old-age or disability benefits is not considered as meeting the dependency requirements for

child's insurance benefits unless the child is the natural child or stepchild of the individual, or was legally adopted in a United States court and met residence, support and age criteria prior to commencement of the individual's entitlement. Thus, a child other than a natural child or stepchild, adopted in a foreign jurisdiction after the date of the adopting parent's entitlement, cannot be considered a dependent for purposes of child's insurance benefits.

The proposed amendment to the veterans' benefit statutes is expected to result in annual cost savings of less than one million dollars. Savings would be realized both by limiting inappropriate benefit payments and through improved administrative efficiency.

Section 204 would amend section 360 of title 38, which affords special consideration regarding payment of compensation in cases where veterans have suffered certain service-connected disabilities affecting a single eye, ear, or kidney in combination with certain non-service-connected disabilities affecting the other eye, ear, or kidney. Under present law, if a veteran has suffered service-connected blindness in one eye, service-connected deafness in one ear, or service-connected loss or loss of use of one kidney, in combination with non-service-connected blindness in the other eye, deafness in the other ear, or severe involvement of the other kidney (resulting in total disability), compensation at the appropriate rate is paid as if the disabilities affecting both organs were service-connected.

Section 360 of title 38 was originally enacted in recognition of the additional disability attendant to non-service-connected loss or loss of use of a second paired organ where service connection is established for the impairment of the first. It serves to equate, in terms of compensation, these types of cases with those where the disability affecting both organs is adjudicated as service-connected.

Section 204 would extend the principle of "paired organ impairment" to certain disabilities of the lungs so that if a veteran has suffered permanent disability of one lung, rated 50 percent or more disabling under the relevant criteria, which is totally disabling in combination with a nonservice-connected disability of the other lung, compensation would be paid at the total disability rate.

Our estimates indicate this proposal would result in less than $1 million in benefit costs and less than $100,000 in administrative costs in any fiscal year.

Title III contains a single proposal, which would extend the authority of the Administrator of Veterans' Affairs to maintain a regional office in the Republic of the Philippines. Under present law, the Administrator is authorized to operate a regional office in the Philippines until September 30, 1985. Section 301 would extend this authority to September 30, 1988.

It has been our experience that the operation of a regional office in the Republic of the Philippines is the most efficacious means of administering the VA programs which provide disability compensation, pensions and educational benefits to tens of thousands of Filipino beneficiaries. In fiscal year 1983, for example, over $125 million in benefits were paid to these individuals. Our proposal would enable this Agency to continue meeting the needs of the residents of the Philippines in a cost-effective manner.

Enactment of section 301 would entail administrative costs of approximately $1.4 million in any fiscal year.

Advice has been received from the Office of Management and Budget that enactment of this legislative proposal would be in accord with the program of the President.

Sincerely,

HARRY N. WALTERS, *Administrator.*

Enclosure.

H.R. ——

A BILL To amend title 38, United States Code, to increase the rates of compensation for disabled veterans and the rates of dependency and indemnity compensation for surviving spouses and children of veterans; and for other purposes.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE

SECTION 1. (a) This Act may be cited as the "Veterans' Disability Compensation and Survivor Benefits Amendments of 1985".

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—DISABILITY COMPENSATION AND DEPENDENCY AND INDEMNITY COMPENSATION RATE INCREASES

RATES OF DISABILITY COMPENSATION

SEC. 101. (a) Section 314 is amended—

(1) by striking out "$66" in subsection (a) and inserting in lieu thereof "$68";

(2) by striking out "$122" in subsection (b) and inserting in lieu thereof "$127";

(3) by striking out "$185" in subsection (c) and inserting in lieu thereof "$192";

(4) by striking out "$266" in subsection (d) and inserting in lieu thereof "$276";

(5) by striking out "$376" in subsection (e) and inserting in lieu thereof "$391";

(6) by striking out "$474" in subsection (f) and inserting in lieu thereof "$493";

(7) by striking out "$598" in subsection (g) and inserting in lieu thereof "$622";

(8) by striking out "$692" in subsection (h) and inserting in lieu thereof "$720";

(9) by striking out "$779" in subsection (i) and inserting in lieu thereof "$810";

(10) by striking out "$1,295" in subsection (j) and inserting in lieu thereof "$1,348";

(11) by striking out "$1,609" and "$2,255" in subsection (k) and inserting in lieu thereof "$1,674" and "$2,347", respectively;

(12) by striking out "$1,609" in subsection (l) and inserting in lieu thereof "$1,674";

(13) by striking out "$1,774" in subsection (m) and inserting in lieu thereof "$1,846";

(14) by striking out "$2,017" in subsection (n) and inserting in lieu thereof "$2,099";

(15) by striking out "$2,255" each place it appears in subsections (o) and (p) and inserting in lieu thereof "$2,347";

(16) by striking out "$968" and "$1,442" in subsection (r) and inserting in lieu thereof "$1,007" and "$1,501", respectively;

(17) by striking out "$1,449" in subsection (s) and inserting in lieu thereof "$1,508"; and

(18) by striking out "$280" in subsection (t) and inserting in lieu thereof "$291".

(b) The Administrator of Veterans' Affairs may adjust administratively, consistent with the increases authorized by this section, the rates of disability compensation payable to persons within the purview of section 10 of Public Law 85-857 who are not in receipt of compensation payable pursuant to chapter 11 of title 38, United States Code.

RATES OF ADDITIONAL COMPENSATION FOR DEPENDENTS

SEC. 102. Section 315(1) is amended—

(1) by striking out "$79" in clause (A) and inserting in lieu thereof "$82";

(2) by striking out "$132" and "$42" in clause (B) and inserting in lieu thereof "$137" and "$43", respectively;

(3) by striking out "$54" and "$42" in clause (C) and inserting in lieu thereof "$56" and "$43", respectively;

(4) by striking out "$64" in clause (D) and inserting in lieu thereof "$66";

(5) by striking out "$143" in clause (E) and inserting in lieu thereof "$148"; and

(6) by striking out "$120" in clause (F) and inserting in lieu thereof "$124".

CLOTHING ALLOWANCE FOR CERTAIN DISABLED VETERANS

SEC. 103. Section 362 is amended by striking out "$349" and inserting in lieu thereof "$363".

RATES FOR DEPENDENCY AND INDEMNITY COMPENSATION FOR SURVIVING SPOUSES

SEC. 104. (a) Subsection (a) of section 411 is amended to read as follows:

"(a) Dependency and indemnity compensation shall be paid to a surviving spouse, based on the pay grade of the person upon whose death entitlement is predicated, at monthly rates set forth in the following table:

"Pay grade	Monthly rate	"Pay grade	Monthly rate
E-1	$495	W-4	$709
E-2	$510	O-1	$626

E-3	$522	O-2	$646
E-4	$556	O-3	$692
E-5	$571	O-4	$731
E-6	$584	O-5	$806
E-7	$613	O-6	$908
E-8	$646	O-7	$982
E-9	[1] $675	O-8	$1,077
W-1	$626	O-9	$1,156
W-2	$651	O-10	[2] $1,266
W-3	$670		

"[1] If the veteran served as sergeant major of the Army, senior enlisted advisor of the Navy, chief master sergeant of the Air Force, sergeant major of the Marine Corps, or master chief petty officer of the Coast Guard, at the applicable time designated by section 402 of this title, the surviving spouse's rate shall be $728.

"[2] If the veteran served as Chairman of the Joint Chiefs of Staff, Chief of Staff of the Army, Chief of Naval Operations, Chief of Staff of the Air Force, or Commandant of the Marine Corps, at the applicable time designated by section 402 of this title, the surviving spouse's rate shall be $1,358."

(b) Subsection (b) of such section is amended by striking out "$55" and inserting in lieu thereof "$57".

(c) Subsection (c) of such section is amended by striking out "$143" and inserting in lieu thereof "$148".

(d) Subsection (d) of such section is amended by striking out "$70" and inserting in lieu thereof "$72".

RATES OF DEPENDENCY AND INDEMNITY COMPENSATION FOR CHILDREN

SEC. 105. Section 413 is amended—

(1) by striking out "$240" in clause (1) and inserting in lieu thereof "$249";

(2) by striking out "$345" in clause (2) and inserting in lieu thereof "$359";

(3) by striking out "$446" in clause (3) and inserting in lieu thereof "$464"; and

(4) by striking out "$446" and "$90" in clause (4) and inserting in lieu thereof "$464" and "$93", respectively.

RATES OF SUPPLEMENTAL DEPENDENCY AND INDEMNITY COMPENSATION FOR CHILDREN

SEC. 106. Section 414 is amended—

(1) by striking out "$143" in subsection (a) and inserting in lieu thereof "$148";

(2) by striking out "$240" in subsection (b) and inserting in lieu thereof "$249"; and

(3) by striking out "$122" in subsection (c) and inserting in lieu thereof "$127".

EFFECTIVE DATE

SEC. 107. Sections 101 through 106 shall take effect on December 1, 1985.

TITLE II—OTHER VETERANS' PROGRAM IMPROVEMENTS

DISCONTINUANCE OF BENEFITS BASED ON SCHOOL ATTENDANCE AS OF THE LAST DATE OF ATTENDANCE

SEC. 201. Section 3012(b) is amended—

(1) by striking out clause (7); and

(2) by redesignating clauses (8), (9), and (10) as clauses (7), (8), and (9), respectively.

ACTIVE DUTY STATUS BASED ON AGR OR ADS SERVICE BY RESERVISTS AND NATIONAL GUARD PERSONNEL

SEC. 202. (a) Paragraph (22) of section 101 is amended in clause (C) by inserting "performed for training purposes under title 10 or" after "full-time duty".

(b)(1) The amendment made by subsection (a) shall be affective with respect to duty performed after September 30, 1985.

(2) Any member or former member of the National Guard or Air National Guard in active guard and reserve or active duty support status as of the date of enactment of this Act shall be eligible for benefits under chapter 37 of title 38, United States Code, if the member (or former member) continuously served in such status for 181 days or more prior to application therefore and is otherwise eligible.

LIMITATION OF CIRCUMSTANCES UNDER WHICH ADOPTED CHILDREN MAY BE CONSIDERED DEPENDENTS

SEC. 203. Section 101(4)(B)(i) is amended—

(1) by striking out "and" at the end of clause (III); and

(2) by adding the following new clause (V): "(V) was adopted by the veteran prior to the date any entitlement of the veteran to benefits under chapters 11 or 15 of this title arose; and".

EXTENSION OF "PAIRED ORGAN" CRITERIA TO DISABILITIES INVOLVING THE LUNGS

SEC. 204. Section 360 is amended—

(1) By inserting after clause (3) "or" followed by a new clause (4) to read as follows: "(4) has suffered permanent service-connected disability of one lung, rated 50 percent or more disabling, which is totally disabling in combination with nonservice-connected disability of the other lung that is not the result of the veteran's own willful misconduct,"; and

(2) by inserting "or such bilateral lung disabilities" after "such total deafness in both ears".

TITLE III—EXTENSION OF AUTHORITY TO OPERATE A REGIONAL OFFICE IN THE REPUBLIC OF THE PHILIPPINES

SEC. 301. Section 230(b) is amended by striking out "1985" and inserting in lieu thereof "1988".

OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS,
Washington, DC, September 10, 1985.

Hon. G.V. (SONNY) MONTGOMERY,
Chairman, Committee on Veterans' Affairs, House of Representatives, Washington, DC

DEAR MR. CHAIRMAN: This will respond to a request from your staff to provide additional information regarding the cost implications of enacting H.R. 3191, which you kindly introduced at our request. H.R. 3191 would amend title 38, United States Code, to re-

quire that non-Federal providers under Medicare furnish care and services to VA beneficiaries in accordance with payment policies similar to Medicare's.

As we advised in our letter of July 23, 1985, transmitting this draft bill to you, we are promulgating regulations to authorize the Agency to adopt a payment system, similar to that used by the Medicare program, for VA-authorized hospital care and services rendered by non-Federal providers to VA beneficiaries. That system would be based on paying predetermined dollar amounts for cases classified by diagnosis-related groups (DRG's). In the past, VA has generally reimbursed hospitals at the level billed if such costs were deemed within reasonable limits. We anticipate that implementation of this more rigorous, new payment mechanism would significantly reduce the cost to VA of the average episode of non-VA care.

As we indicated in our transmittal, however, enactment of a measure like H.R. 3191, which would establish a compliance mechanism, is necessary to assure the success of the proposed payment system.

Accordingly, we estimate that promulgation of these regulations and enactment of H.R. 3191 would have the effect of reducing the cost of an average episode of care, resulting in cost avoidance of some $6 million in fiscal year 1986 and $7 million annually for fiscal years 1987 through 1990.

Sincerely,

EVERETT ALVAREZ, Jr.,
Deputy Administrator
(For Harry N. Walters, Administrator).

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS,
Washington, DC, July 23, 1985.

Hon. THOMAS P. O'NEILL, Jr.,
Speaker, House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: There is transmitted herewith a draft bill "To amend title 38, United States Code, to require that non-Federal providers of hospital care and services receiving direct payment of Medicare funds for services to Medicare beneficiaries provide similar services to VA beneficiaries under similar VA payment policies." We request that the bill be referred to the appropriate Committee and recommend its prompt enactment.

The purpose of this legislative proposal is to limit the increase in the costs to VA our contract hospitalization program by requiring non-Federal providers that furnish hospital care and services to Medicare beneficiaries to provide similar services to VA beneficiaries, and to accept for such services VA payments made in accordance with VA regulations. The draft bill would authorize the termination of eligibility of a Medicare provider that either would not accept VA payments made in accordance with VA regulations or would not accept VA beneficiaries as patients on the same basis as Medicare beneficiaries.

This aim now has added importance, since the Medicare program has adopted a payment system based on paying predetermined

dollar amounts for cases identified as falling within Diagnosis-Related Groups (DRGs) rather than paying for all or a specified part of the actual cost of the hospital care provided. The adoption by the Medicare program of this payment system already has achieved very substantial savings to the Government, and it clearly is in the Government's interest to use a similar system for paying the non-Federal hospital expenses of VA beneficiaries as in paying for Medicare beneficiaries.

The VA is promulgating regulations which will authorize the Agency to use a payment system, similar to that used by the Medicare program, based on paying predetermined dollar amounts for identified DRGs. Significant dollar savings are expected to result from implementation of this change in the method of paying for hospital services rendered by non-Federal providers to VA beneficiaries just as has occurred in the Medicare program. At the same time, it is recognized that the number of VA beneficiaries in non-Federal hospitals for whom VA will pay the costs of care is far less than the analogous number of Medicare beneficiaries paid for by Medicare, involving only about 30,000 episodes of non-VA hospital care nationwide. Our concern is that some non-Federal providers that have agreed to treat Medicare beneficiaries may nevertheless refuse to accept VA beneficiaries on a similar basis.

To help assure VA's use of a system similar to Medicare's for paying non-Federal providers of hospital services, the legislation proposed here would require that non-Federal providers of hospital care and services to Medicare beneficiaries must accept VA beneficiaries as patients to the same extent as Medicare beneficiaries, and must accept VA payments for their services to VA beneficiaries made in accordance with VA regulations as full payment for such services. Medicare beneficiaries to some extent are personally subject to deductibles, co-insurance, and other payments. Since VA beneficiaries are not personally subject to such deductibles, co-insurance, or other payments, the actual amounts paid by VA to such providers may to that extent exceed the amount which Medicare would pay such provider in a similar case.

The draft bill would also authorize the Administrator, upon finding noncompliance by a provider with this Act in accordance with procedures established by the Administrator after consulting the Secretary of Health and Human Services, to report such noncompliance to the Secretary. Only inpatient providers of hospital care or services who either refuse to accept VA beneficiaries as patients, or who refuse to accept VA payment in accordance with VA regulations as full payment for their services similar to the manner in which Medicare payments are accepted by such providers, would be considered not to be in compliance with this Act. The Secretary is authorized to arrange for prompt corrective action, or to terminate such provider's status as an eligible Medicare provider upon finding that such provider has failed to comply with the Act here proposed.

It is not possible to estimate the amount of cost savings which would be associated with the enactment of this legislative proposal. It is not known with any degree of specificity how many non-Federal inpatient providers of health services, absent this legislation, would not accept VA beneficiaries as patients if their payments by

VA were limited to the amount set forth in VA regulations as payments in full. It is clear, however, that overall savings would result from this bill's enactment.

We have been advised by the Office of Management and Budget that there is no objection to the submission of this draft bill to the Congress, and its enactment would be consistent with the Administration's objectives.

Sincerely,

HARRY N. WALTERS, *Administrator.*

A BILL To amend title 38, United States Code, to require that non-Federal providers of hospital care and services receiving direct payment of Medicare funds for services to Medicare beneficiaries provide similar services to VA beneficiaries under similar VA payment policies.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, A new section 625 is added to Subchapter III of Chapter 17, which new section 625 reads as follows:

"§ 625. Requirement that Providers accept Medicare and VA Beneficiaries on Similar Basis, and accept VA payments as payments in full.

"(a) For purposes of this Act, 'VA beneficiaries' means all veterans and other persons for whose hospital care outside Federal facilities VA is authorized to pay.

"(b) Notwithstanding any other provision of this title or of title 42, United States Code, or other law, any non-Federal provider of hospital services to any Medicare beneficiary must also accept VA beneficiaries on a similar basis, and must accept payments made by VA in accordance with VA regulations as payments in full.

"(c) Upon a finding by the Administrator, made in accordance with procedures developed in consultation with the Secretary of Health and Human Services, that a Medicare provider has failed to comply with this Act, the Administrator, if unable to obtain prompt corrective action, will report such finding to the Secretary for possible corrective action or for possible termination of the provider's agreement with the Secretary entered into pursuant to 42 U.S.C. § 1395cc(a). Thereafter, in addition to the bases for termination set forth in 42 U.S.C. § 1395cc(b), the Secretary may terminate such agreement with the provider if the Secretary determines that the provider has failed to comply with this Act."

SEC. 2. The Table of Parts and Chapters at the beginning of title 38, United States Code, and the table of sections at the beginning of chapter 17 of such title are each amended by inserting after

"624. Hospital care, medical services and nursing home care abroad."

the following:

"625. Requirement that Providers accept Medicare and VA Beneficiaries on Similar Bases, and accept VA payments as payments in full."

SECTION-BY-SECTION ANALYSIS

Section 1 of this bill would amend title 38, United States Code, by adding new section 625, which would require non-Federal providers of hospital care and services to Medicare beneficiaries to

provide similar services to VA beneficiaries and to accept VA payments made in accordance with VA regulations as payments in full for such services. Section 625 contains three subsections.

Subsection a defines VA beneficiaries as persons for whose hospital care outside Federal facilities VA has been authorized to pay.

Subsection b provides that any non-Federal provider of hospital care and services to Medicare beneficiaries must also accept VA beneficiaries on a similar basis, and must accept payments made by VA in accordance with VA regulations as payments in full.

Subsection c provides discretionary authority for the Government to enforce new section 625. It authorizes the VA to prescribe procedures for identifying providers not in compliance with this Act, and authorizes the VA to report such noncompliance to the Secretary of Health and Human Services. The Secretary is then authorized to seek corrective action or to terminate that provider's agreement with the Medicare program, based on the provider's noncompliance with section 625.

Section 2 of the bill amends both the Table of Parts and Chapters at the beginning of title 38, and the table of sections at the beginning of chapter 17 by inserting references to proposed section 625 and its caption following the corresponding provisions of section 624.

Changes in existing law made by the draft bill are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is italicized and existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

PART II—GENERAL BENEFITS

CHAPTER 17.—HOSPITAL, DOMICILIARY, AND MEDICAL CARE

Subchapter I—General

Sec.
601. Definitions.
602. Presumption relating to psychosis.

Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical Treatment

. . . . . .

Subchapter III—Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

621. Power to make rules and regulations.
622. Statement under oath.
623. Furnishing of clothing.
624. Hospital care, medical services and nursing home care abroad.

"§ 625. Requirement that Providers accept Medicare and VA Beneficiaries on Similar Basis, and accept VA payments as payments in full.

"(a) For purposes of this Act, 'VA beneficiaries' means all veterans and other persons for whose hospital care outside Federal facilities VA is authorized to pay.

"(b) Notwithstanding any other provision of this title or of title 42, United States Code, or other law, any non-Federal provider of hospital services to any Medicare beneficiary must also accept VA beneficiaries on a similar basis, and must accept payments made by VA in accordance with VA regulations as payments in full.

"(c) Upon a finding by the Administrator, made in accordance with procedures developed in consultation with the Secretary of Health and Human Services, that a Medicare provider has failed to comply with this Act, the Administrator, if unable to obtain prompt corrective action, will report such finding to the Secretary for possible corrective action or for possible termination of the provider's agreement with the Secretary entered into pursuant to 42 U.S.C. § 1395cc(a). Thereafter, in addition to the bases for termination set forth in 42 U.S.C. § 1395cc(b), the Secretary may terminates such agreement with the provider if the Secretary determines that the provider has failed to comply with this Act."

* * * * * * *

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS,
Washington, DC, April 18, 1985.

Hon. THOMAS P. O'NEILL, Jr.,
Speaker of the House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: There is transmitted herewith a draft bill to amend title 38, United States Code, to revise eligibility for VA medical care. We request that the bill be referred to the appropriate committee for consideration and enactment promptly.

Historically, the primary mission of the VA health care system has been to furnish care to service-connected disabled veterans and to veterans unable to pay for needed medical care. In 1970, however, Congress extended eligibility for VA hospital and nursing home care to veterans 65 years of age and older, without regard to financial need. In sharp contrast, legal eligibility of most nonservice-connected veterans under 65 is based on their inability to defray the cost of needed VA care.

The law's disparate treatment of nonservice-connected veterans on the basis of age raises a serious issue. VA may only provide medical care to nonservice-connected veterans to the extent facilities and resources are available. Demographic projections indicate that the number of veterans who will be eligible for care as our veteran population ages is increasing significantly. Fairness dictates that age alone should not be a basis entitling one to VA care. Rather, VA should be treating those nonservice-connected veterans who lack the means to obtain such treatment elsewhere, regardless of age.

This draft bill, accordingly, is intended to overcome this inequity. Our proposal would amend title 38 to authorize VA to determine that nonservice-connected veterans over the age of 65 who are not otherwise eligible for, and seek, VA care have a financial as well as a medical need to receive that care. This change would enable VA to sustain the quality of care provided to the most deserving veterans—those with service-connected disabilities and those without resources to defray all or part of their health care expenses.

The change would also clarify and extend a framework which Congress provided for in 1980 when it enacted Public Law 96-330 and deleted provisions of law prohibiting VA from looking behind a veteran's assertions of financial need. Thus, the bill would specifically provide for the Administrator to promulgate regulations identifying the conditions under which veterans may be considered unable to defray medical expenses. It would also establish in law that a nonservice-connected veteran whose total income and assets, as defined in the improved pension program, are below an eligibility level set at twice the VA pension rate—a level currently of just under $15,000 for a veteran with one dependent—would be deemed unable to defray the cost of any needed health care.

Under this proposal, VA would continue to fulfill its primary mission of care for service-connected veterans. Furthermore, this proposal would not alter the role VA has played in providing medical care, within the limits of VA facilities, to:

(1) Veterans who were prisoners of war;

(2) Veterans of the Spanish-American War, Indian Wars, Mexican border period, or of World War I;

(3) Vietnam War veterans exposed to certain herbicides during military service;

(4) Certain veterans exposed to ionizing radiation during military service; and

(5) VA pensioners.

The inequity inherent in the existing eligibility scheme and debate surrounding the design and administration of a means test have delayed full implementation of Public Law 96-330. Enactment of this bill, however, would enable VA to develop a fair, effective screening system to help assure that those veterans with greatest need—the service-connected and the financially disadvantaged—can avail themselves of VA care. Regulations, provided for in the bill, would establish the circumstances under which a veteran, whose income and asset value exceed the proposed twice-pension-rate standard, would receive VA care. The central elements of this system, as applied to veterans with means above that standard, would provide for the following:

(1) In most cases, these veterans would not be eligible for VA health care unless the veteran's out-of-pocket medical expenses exceeded certain amounts.

(2) These out-of-pocket expenses, called the "expected medical expense contribution", would be an increasing share of the amount by which the total of the veteran's family income and asset value exceed the eligibility level. This share would increase progressively with income, requiring higher income veterans to finance a larger amount of their medical expenses before entering the VA system.

(3) In emergency or extraordinary circumstances, these veterans could receive care in the VA system but would be billed for their share of the cost up to their expected medical expense contribution.

(4) In exceptional and unusual circumstances, the Administrator could waive in whole or in part the veteran's expected medical expense contribution in order to avoid substantial hardship.

Enactment of this bill and implementation of a screening mechanism would enable us to assure that VA health care resources are targeted to those most in need. We project that the proposal would result in a lower rate of growth in VA's medical care and construction budgets than otherwise would be needed, while at the same time insuring the availability of resources to sustain a quality health care system for veterans. We are confident that enactment of this proposal would permit the VA health care system to be more responsive to those veterans with the greatest need for, and highest claim to, its services.

We have been advised by the Office of Management and Budget that there is no objection to the submission of this bill to the Congress, and its enactment would be in accord with the program of the President.

Sincerely,

HARRY N. WALTERS, *Administrator.*

Enclosures.

A BILL To amend title 38, United States Code, to revise veterans' eligibility for health care from the Veterans' Administration, and for other purposes.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, that section 610(a) of title 38, United States Code, is amended to read as follows:

"(a) The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to—

"(1) any veteran for a service-connected disability;

"(2) a veteran for a disability incurred or aggravated in line of duty if the disability was responsible for the veteran's discharge or release from the active military, naval, or air service;

"(3) a veteran for any disability (A) who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation, or (B) who, but for a suspension pursuant to sectin 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement described in such section;

"(4) a veteran who is a former prisoner of war for any disability;

"(5) any veteran of the Spanish American war, Indian Wars, Mexican border period, or of World War I, for any disability;

"(6) a veteran who meets the conditions of subsection (e) of this section; and

"(7) any veteran for a nonservice-connected disability if such veteran is unable to defray the expenses of necessary hospital or nursing home care.".

SEC. 2. Section 622 of title 38, United States Code, is amended—

(a) by adding "(a)" at the beginning;

(b) by striking out "610(a)(1)(B)", and inserting in lieu thereof "610(a)(7)";

(c) by striking out "or" at the end of clause (2);

(d) by inserting "or" at the end of clause (3);

(e) by inserting after subsection (3) the following new clause (4):

"(4) a veteran whose income (during the twelve months preceding the date of such veteran's application for needed care) as determined in accordance with the criteria of section 503 of this title (with the exception of the veteran's unreimbursed medical expenses) when added to the value of the veteran's assets (as defined by the Administrator) and including in the computation the income and value of assets of a veteran's spouse with whom the veteran is living and the income and assets of any children of the veteran in the veteran's custody (or to whose support the veteran is reasonably contributing), is equal to or less than twice the maximum annual rate of pension provided under–

"(i) subsection 521(b) of this title if the veteran is unmarried (or married but not living with or reasonably contributing to the support of such veteran's spouse) and there is no child of the veteran in the veteran's custody or to whose support the veteran is reasonably contributing; or

"(ii) subsection 521(c) of this title if the veteran is married and living with or reasonably contributing to the support of such veteran's spouse, or if there is a child of the veteran in the veteran's custody or to whose support the veteran is reasonably contributing;"

(f) by adding a new subsection (b) to read as follows:

"(b) The Administrator shall prescribe regulations identifying the circumstances under which the Administrator will consider a veteran to be unable to defray expenses of needed care. Such regulations shall include a schedule of unreimbursed medical expense contributions that a veteran will be expected to make before he or she will be deemed unable to defray expenses of needed care. Such regulations shall provide that the Administrator shall—

"(1) develop such schedule based progressively upon total income and assets, as defined in subsection (a)(4);

"(2) base determinations of inability to defray by comparing the contribution level specified in the schedule of unreimbursed medical expense contributions with the veteran's total unreimbursed expenditures for his or her medical care during the 12 months preceding the date of such veteran's application for needed care;

"(3) require from any veteran who is an applicant for benefits under section 610(a)(7), 610(b)(2), 624(c), or 632(a)(2) of this title such information, proofs, and evidence as the Administrator determines to be necessary in order to determine (A) the unreimbursed expenditures for medical care made by such veteran and (B) the income and the value of any assets of such veteran and of any spouse or child of such veteran;

"(4) assess charges, to the extent a veteran has not made his or her expected unreimbursed medical expense contribution for care, for medical services furnished in extraordinary or emergency circumstances or for examinations conducted to determine if care is required; and

"(5) in exceptional and unusual circumstances, and to avoid substantial hardship in the case of a veteran, waive in full or in part, in accordance with procedures developed under these regulations, any requirement under these regulations that such veteran incur a specified level of expenditures for his or her medical care in order to be deemed unable to defray the costs of needed care; such waiver shall only be considered upon application of the veteran and shall not be granted categorically, either for categories of illness, expenses, income, procedures, types of care, or veterans." and

(g) by adding a new subsection (c) to read as follows:

"(c) Any monies collected or received by the Veterans Administration on behalf of the United States as a result of recovery under this section shall be deposited to the United States Treasury as a proprietary receipt.".

Section-by-Section Analysis

Section 1 of the bill would amend section 610(a) of title 38, United States Code, which provides basic eligibility to certain veterans for hospital and nursing home care from the Veterans Administration (VA).

This section of the bill would amend section 610(a) in its entirety. It would delete entirely the substance of paragraph (6) which currently authorizes VA to furnish care to veterans 65 years of age or older without regard to ability to defray the cost of that care. As revised, section 610(a) would have the effect of requiring VA to determine whether nonservice-connected veterans over the age of 65 who seek VA care have a financial as well as medical need to receive that care. The bill's revision also reflects technical changes in section 610(a) and a reordering of its paragraphs.

Section 2 of the bill would amend section 622 of title 38 which describes circumstances under which an individual applying for VA health-care benefits will be deemed, for purposes of eligibility, unable to defray such expenses. This section would add a fourth situation which would establish sufficient evidence of financial need: under this proposal, a veteran would be considered to be unable to defray expenses for VA health care if that veteran has means—

consisting of family income, during the twelve months preceding the veteran's applying for care, and assets--equal to, or less than twice the maximum annual base pension rate. Income, under this provision, would be calculated in accordance with the criteria of the new pension program, with the exception of expenditures incurred by the veteran for his or her medical care. Such unreimbursed expenditures would be considered only in connection with a veteran whose income and assets are in excees of double the maximum annual pension rate.

Section 2 of the bill would also add a new subsection (b) to section 622 of title 38. This new subsection (b) would call for the promulgation of regulations under which the Administrator would determine inability to defray expenses for medical care. Such regulations would be applied to all veterans whose eligibility for care is predicated on an "inability to defray" and who are not otherwise deemed unable to defray under new section 622(a). This subsection would require that the determination of such veteran's inability to defray would be based on whether, during the twelve months before seeking VA care, the veteran had incurred unreimbursed out-of-pocket expenses for his or her medical care exceeding levels specified in regulations. These medical expense levels, called the expected medical expense contribution, would form the basis for evaluating the veteran's inability to defray further medical costs. The expected medical expense contribution levels would be set out in the form of a schedular table in the regulations to be promulgated under the bill. The schedule would be based progressively upon total income and assets, as defined in new subsection (a) (4) of section 622 of title 38, United States Code. If the veteran presented reasonable evidence that out-of-pocket payments for his or her care to private providers and third parties during the preceding twelve months equaled or surpassed the expected medical expense contribution, the veteran would be admitted. The Administrator would establish under the regulations to be promulgated such procedures as the Administrator deems necessary for verifying a veteran's statements of income, assets, and unreimbursed medical expenditures in support of an application for medical care.

Although a veteran might not be eligible for care under the proposed means test, VA could still admit that person where he or she requires emergency care or care in certain extraordinary circumstances. The bill contemplates that VA would charge such veteran for the cost of the care up to his or her expected medical expense contribution. Implementing regulations would also provide for assessing charges up to that level for any examination provided to determine if care is required.

The bill would also provide for the Administrator to establish by regulation procedures for granting requests, in exceptional circumstances or to avoid substantial hardship, to waive in full or in part, the requirement that a veteran incur a specified level of unreimbursed expenditures to be deemed unable to defray the costs of needed care. The bill provides that such waivers would only be considered on a case by case basis upon application of the veteran. Waivers would not be granted categorically, either for categories of illness, expenses, income, procedures, types of care, or veterans.

The bill would add a new subsection (c) to section 622 which would provide that any monies collected under this section will be deposited as a proprietary receipt and will not be retained by the VA to supplement its appropriation or taken as a credit against the appropriation.

CHANGE IN EXISTING LAW MADE BY DRAFT BILL

Changes in existing law made by this bill are shown as follows (existing law proposed to be omitted is enclosed in brackets, new matter is italicized, existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

* * * * * * *

PART II. GENERAL BENEFITS

* * * * * * *

CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

* * * * * * *

Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical Treatment

§ 610. Eligibility for hospital nursing home and domiciliary care

[(a) The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to—

[(1)(A) any veteran for a service-connected disability; or (B) any veteran for a non-service-connected disability if such veteran is unable to defray the expenses of necessary hospital or nursing home care;

[(2) a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty;

[(3) a person (A) who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation, (B) who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such person's continuing eligibility for such care is provided for in the judgment or settlement described in such section;

[(4) a veteran who is a former prisoner of war;

[(5) a veteran who meets the conditions of subsection (e) of this section; and

[(6) any veteran for a non-service-connected disability if such veteran is sixty-five years of age or older.]

(a) The Administrator, within the limits of Veterans' Adminstration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to—

(1) any veteran for a service-connected disability;

(2) a veteran for a disability incurred or aggravated in line of duty if the disability was responsible for the veteran's discharge or release from the active military, naval, or air service;

(3) a veteran for any disability (A) who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation, or (b) who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in judgment or settlement described in such section;

(4) a veteran who is a former prisoner of war for any disability;

(5) any veteran of the Spanish-American War, Indian Wars, Mexican border period, or of World War I, for any disability;

(6) a veteran who meets the conditions of subsection (e) of this section; and

(7) any veteran for a nonservice-connected disability if such veteran is unable to defray the expenses of necessary hospital or nursing home care.

* * * * * * *

Subchapter III—Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

* * * * * * *

§ 622. Evidence of inability to defray necessary expenses

(a) For the purposes of sections **[**610(a)(1)(B)**]** *610(a)(7),* 601(b)(2), 624(c), and 632(a)(2) of this title, the fact that an individual is—

(1) eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(2) a veteran with a service-connected disability; **[**or**]**

(3) in receipt of pension under any law administered by the Veterans' Administration; *or*

(4) a veteran whose income (during the twelve months preceding the date of such veteran's application for needed care) as determined in accordance with the criteria of section 503 of this title (with the exception of the veteran's unreimbursed medical expenses) when added to the value of the veteran's assets (as defined by the Administrator) and including in the computation the income and value of assets of a veteran's spouse with whom the veteran is living and the income and assets of any children of the veteran in the veteran's custody (or to whose support the veteran is reasonably contributing), is equal to or less than twice the maximum annual rate of pension provided under—

(i) subsection 521(b) of this title if the veteran is unmarried (or married but not living with or reasonably contributing to the support of such veteran's spouse) and there is no child of the veteran in the veteran's custody or to whose support the veteran is reasonably contributing; or

(ii) subsection 521(c) of this title if the veteran is married and living with or reasonably contributing to the support of such veteran's spouse, or if there is a child of the veteran in the veteran's custody or to whose support the veteran is reasonably contributing;

shall be accepted as sufficient evidence of such individual's inability to defray necessary expenses.

(b) The Administrator shall prescribe regulations identifying the circumstances under which the Administrator will consider a veteran to be unable to defray expenses of needed care. Such regulations shall include a schedule of unreimbursed medical expense contributions that a veteran will be expected to make before he or she will be deemed unable to defray expenses of needed care. Such regulations shall provide that the Administrator shall—

(1) develop such schedule based progressively upon total income and assets, as defined in subsection (a)(4);

(2) base determinations of inability to defray by comparing the contribution level specified in the schedule of unreimbursed medical expense contributions with the veteran's total unreimbursed expenditures for his or her medical care during the 12 months preceding the date of such veteran's application for needed care;

(3) require from any veteran who is an applicant for benefits under section 610(a)(7), 610(b)(2), 624(c), or 632(a)(2) of this title such information, proofs, and evidence as the Administrator determines to be necessary in order to determine (A) the unreimbursed expenditures for medical care made by such veteran and (B) the income and the value of any assets of such veteran and of any spouse or child of such veteran;

(4) assess charges, to the extent a veteran has not made his or her expected unreimbursed medical expense contribution for care, for medical services furnished in extraordinary or emergency circumstances or for examinations conducted to determine if care is required; and

(5) in exceptional and unusual circumstances, and to avoid substantial hardship in the case of a veteran, waive in full or in part, in accordance with procedures developed under these regulations, any requirement under these regulations that such veteran incur a specified level of expenditures for his or her medical care in order to be deemed unable to defray the costs of needed care; such waiver shall only be considered upon application of the veteran and shall not granted categorically, either for categories of illness, expenses, income, procedures, types of care, or veterans.

(c) Any monies collected or received by the Veterans Administration on behalf of the United States as a result of recovery under this section shall be deposited to the United States Treasury as a proprietary receipt.

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS,
Washington, DC, May 7, 1985.

Hon. THOMAS P. O'NEILL, Jr.,
Speaker of the House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: Forwarded herewith is a draft of proposed legislation "To amend title 38 of the United States Code to provide for the right of the United States to collect the costs of hospital, nursing home, or outpatient medical care furnished by the Veterans Administration to veterans with no service-connected disabilities to the extent that they have health insurance or similar contracts or rights with respect to such care and for other purposes."

The proposed legislation would permit Veterans Administration medical facilities to collect from third party payers the reasonable cost of health and medical care provided by such facilities to a veteran with no service-connected disabilities who has private health insurance coverage. This measure will result in considerable savings to the Federal Government.

Private health insurance includes coverage provided through employment at no cost to employees, coverage for which the employee and employer share the cost, and coverage paid for entirely by the beneficiary.

The proposed legislation would not apply to Medicare and Medicaid benefits. Payments under group income protection plans that pay a fixed sum per day, week, or month while a beneficiary is disabled would also not be subject to Veterans Administration collection.

The measure would preclude the exclusion of VA health care costs in any new or renewed private health insurance contract. Over the past few years many insurance companies have excluded the Federal Government and its agencies from reimbursement by incorporating exclusions in the contracts. These insurance companies are currently collecting payments from veteran policy holders, but do not have to pay benefits when a VA health care facility is used for their care. Furthermore, the veteran policy holders do not receive any reduction in their premiums even though payment is not made when their care or treatment is furnished by a VA health care facility.

This proposal is similar to S. 759, 96th Congress (H.R. 3475), which also authorized reimbursement from insurance policies. That legislation provided for recovery under workers compensation laws, no-fault insurance, and crime-victims' acts in addition to health insurance. Subsequent legislation removing the provisions about health insurance was enacted as section 106, Pub. L. No. 97-72, now codified as section 629, title 38, United States Code.

The measure would be effective upon enactment.

The proposed legislation would authorize the VA to seek reimbursement for medical care and services furnished on an inpatient and outpatient basis. Its enactment could result in reimbursements to the U.S. Treasury of $65 million in 1986; $247 million in 1987; $265 million in 1988; $275 million in 1989; and $285 million in 1990.

We request that this bill be referred to the appropriate Committee and recommend its prompt and favorable consideration. A more detailed section-by-section analysis of the bill is enclosed.

We have been advised by the Office of Management and Budget that there is no objection to the submission of this draft bill to the Congress, and its enactment would be in accord with the program of the President.

Sincerely,

HARRY N. WALTERS, *Administrator.*

Enclosures.

A BILL To amend title 38 of the United States Code provide for the right of the United States to collect the costs of hospital, nursing home, or outpatient medical care furnished by the Veterans Administration to veterans with no service-connected disabilities to the extent that they have health insurance or similar contracts or rights with respect to such care and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 629 of title 38, United States Code, is amended by striking out section 629 in its entirety and inserting in lieu thereof:

SEC. 629. Recovery by the United States of the cost of certain care and services.

(a) In any case in which a veteran is furnished care and services under this chapter for a nonservice-connected disability that was incurred—

(1) incident to the veteran's employment and the disability is covered under a workers' compensation law or plan that provides reimbursement for or indemnification of the cost of health care and services provided to the veteran by reason of disability,

(2) as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparation insurance,

(3) as the result of a crime of personal violence that occurred in a State, or a political subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such crime, or

(4) by a veteran with no service-connected disabilities who is entitled to care, or reimbursement for the expenses of care under an insurance policy, or contract, medical, or hospital service agreement, membership, or subscription contract, or similar arrangement for the purpose of providing, paying for, or reimbursing expenses for health services,

the United States has the right to recover or collect the reasonable costs of such care and services from the State, or political subdivision of a State, employer, employer's insurance carrier, automobile accident reparations insurance carrier, or insurance, medical services, or health plan carrier, or contractor, as appropriate, to the extent that the veteran, or the provider of care and services to the veteran, would be eligible to receive reimbursement or indemnifica-

tion for such care and services if the care and services had not been furnished by a department or agency of the United States.

(b) If the insurance, medical service, or health plan includes a requirement for a deductible or copayment by the beneficiary to the plan, then the amount that the United States may collect under this section shall be the reasonable cost of the care provided less the appropriate deductible or copayment amount.

(c) The amount that may be recovered or collected by the United States under subsection (a) of this section may not exceed the lesser of (1) an amount equal to the reasonable cost of the care and services furnished the veteran under this chapter, as determined by the Adminsitrator, or (2) the maximum amount specified by the law of the State or political subdivision concerned or by any relevant contractual provision to which the veteran was a party or was subject. The Administrator shall prescribe regulations and may enter into agreements with insurance, medical service, or health plan carriers, or contractors for the determination of the reasonable cost of care and services under clauses (1) of the preceding sentence, and any determination of such reasonable value by the Administrator under such clause shall be made in accordance with such regulations or agreements. Regulations under the preceding sentence shall be prescribed only after notice and opportunity for public comment.

(d) Notwithstanding subsections (a) and (b), collection may not be made under this section in the case of a plan administered under title XVIII or XIX of the Social Security Act (42 U.S.C. § 1395 et seq.).

(e)(1) The United States shall, as to the right provided in subsection (a) of this section, be subrogated to any right or claim that the veteran or the veteran's personal representative, successor, dependents, or survivors may have against a State or political subdivision of a State, an employer, an employer's insurance carrier, an automobile accident reparations insurance carrier, insurance, medical service, or health plan carrier, or contractor.

(2)(A) In order to enforce any right or claim to which it is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by the veteran or the veteran's personal representative, successor, dependents, or survivors against a State or policital subdivision of a State, an employer, an employer's insurance carrier, an automobile accident reparation insurance carrier, insurance, medical service, or health plan carrier, or contractor.

(B) If—

(i) no such action or proceeding has been commenced within one hundred and eighty days after the first day on which care and services for which recovery is sought were furnished to the veteran by the Veterans' Administration under this chapter, and

(ii) the United States has sent written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute legal proceedings,

the United States may, sixty days after the mailing of such notice, institute and prosecute legal proceedings against the State, politi-

cal subdivision, employer, employer's insurance carrier, automobile accident reparations insurance carrier, insurance, medical service, or health plan carrier or contractor.

(f) The Administrator may compromise, settle, or waive any claim which the United States has by virtue of subsection (a) of this section.

(g) The Administator may enter into contracts or agreements with individuals or organizations for services to recover or collect amounts dues the United States pursuant to subsection (a) of this section. Notwithstanding section 3302(b) of title 31, such contracts or agreements may provide that a fee an individual or organization charges to recover or collect amounts due the United States is payable from the amount recovered or collected. Such contracts or agreements shall provide that—

(1) the Administrator retains that authority to resolve a dispute, compromise a claim, end collection action, and refer a matter to the Attorney General to bring a civil action; and

(2) the individual or organization is subject to—

(A) section 552a(m) of title 5, and sections 3301 and 4132 of title 38; and

(B) laws and regulations of the United States Government and State governments related to collection practices.

(h) A veteran eligible for care and services under this chapter may not be denied such care and services by reason of this section.

(i) No law of any State or of any political subdivision of a State, and no provision of any contract or agreement, including but not limited to insurance, medical service, or health plan, entered into, renewed, or modified under any State law, after the effective date of this section, shall operate to prevent recovery or collection by the United States (1) under subsections (a)(1), (2), or (3) of this section, for care and services furnished under this chapter to any veteran for a nonservice-connected disability, or (2) under section (a)(4) of this section, for care and services furnished under this chapter to any veteran with no service-connected disabilities, or (3) under section 611(b) of this title for care and services furnished under such section to an individual as a humanitarian service in an emergency case. The renewal of a contract or agreement within the meaning of this section includes the exercise of an insurer's right to modify the premiums or coverage of such contract or agreement or the first opportunity to exercise that right after the effective date of this section.

(j) Any monies collected or received by the Veterans Administration on behalf of the United States as a result of recovery under this section shall be deposited in miscellaneous receipts of the United States Treasury as a proprietary receipt.

(k) Clinical records of a veteran who is a beneficiary of a plan described in subsection (a)(4) of this section from which plan recovery or collection is sought pursuant to this section shall be made available for inspection and review by representative of such plan.

(l) This Act becomes effective upon enactment of this bill.

SECTION-BY-SECTION ANALYSIS OF DRAFT BILL

A bill "To amend title 38 of the United States Code to provide for the right of the United States to collect the costs of hospital, nursing home, or outpatient medical care furnished by the Veterans Administration to veterans with no service-connected disabilities to the extent that they have health insurance or similar contracts or rights with respect to such care and for other purposes."

The draft bill adds language to section 629, chapter 17 which would authorize the United States to recover costs expended for medical care provided to veterans with no service-connected disabities where the veteran is entitled to care, or reimbursement for the expenses of care, pursuant to an insurance policy or contract or similar agreement.

Subsection (a)

Subparts (a)(1), (2), and (3) of section 629 remain unchanged, except that the word "or" has been deleted from the end of subsection (a)(2) and added to the end of subsection (a)(3).

A new subpart (a)(4) is added to authorize the United States to collect the cost of care provided to veterans with no service-connected disabilities who have coverage under a health insurance policy or similar contract. This authority would be in addition to the current authority to collect the cost of medical care furnished for a nonservice-connected disability when the need for care was incident to the veteran's employment under a workers' compensation law or plan, was as a result of a motor vehicle accident under a "no-fault" insurance plan, or was covered by a "victims of crime" compensation fund.

The United States would be given the independent right to collect the reasonable cost of the treatment rendered, to a veteran with no service-connected disabilities, from a health insurance carrier, health maintenance organization or employer-sponsored medical plan.

Subsection (b)

This is an entirely new subsection. The United States will look to the health insurance carrier or similar entity for reimbursement within the limits of the policy.

Subsection (c)

This is the same as subsection (b) in the current statute with the addition of language to authorize the United States to collect the cost of care rendered, to a veteran with no service-connected disabilities, from a health insurance carrier or similar entity. After public review and comment, the Administrator would prescribe regulations on the program's implementation, addressing such issues as Health Maintenance Organization enrollment, self-administered employer health plans, and the use of other mechanisms required by some private health insurers. The Administrator would be authorized to enter into agreements with health insurance carriers or similar entities to determine the reasonable cost of care and services.

Subsection (d)

This new subsection excludes collection when the cost of treatment rendered is covered by Medicare or Medicaid. In addition, this subsection would not permit private insurance companies to collect from Medicare in cases where Medicare is first payor.

Subsection (e)

This is the same as subsection (c) in the current statute with the addition of language to authorize the United States to collect the cost of care rendered, to a veteran with no service-connected disabilities, from a health insurance carrier or similar entity.

Subsection (f)

The Administrator would have authority to waive, settle, or compromise any claim of the United States pursuant to this section. Similar authority has been delegated to the Administrator with respect to claims under the Federal Medical Care Recovery Act, section 2652(b) of title 42, and the Federal Claims Collection Act, section 3711(a)(2) of title 31.

Subsection (g)

This subsection is patterned after section 3718 of title 31, which authorizes the head of an agency to contract for collection services to recover indebtedness owed the United States. It is included in the bill to remove any doubt about the Administrator's authority to contract for collection services under this section.

Subsection (h)

This is the same as subsection (d) in the current statute.

Subsection (i)

This is the same as subsection (e) of the current statute with the addition of language to authorize the United States to collect the cost of care rendered, to a veteran with no service-connected disabilities, from a health insurance carrier or similar entity.

In addition, clauses in health insurance contracts or similar plans which excluded from coverage medical care rendered by the United States are prohibited. The subsection also sets forth the time that the prohibition against excluding the United States becomes effective in such contracts or plans. Superfluous language describing the scope of subsection (a) is deleted.

Subsection (j)

Any monies collected under this section will be deposited in miscellaneous receipts of the Treasury as a proprietary receipt, i.e., collections from the sale of a Government product or service to the public, and will not be retained by the VA to supplement its appropriation or taken as a credit against the appropriation.

Subsection (k)

This subsection requires that the clinical records of beneficiaries of health plans from which collections are being sought be made available for inspection and review by the plan's representatives.

Subsection (l)

This sets forth the date of enactment as the effective date of the act.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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PART II. GENERAL BENEFITS

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CHAPTER 11—COMPENSATION FOR SERVICE-CONNECTED DISABILITY OR DEATH

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Subchapter II—Wartime Disability Compensation.

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§ 314. Rates of wartime disability compensation.

For the purposes of section 310 of this title—

(a) if and while the disability is rated 10 percent the monthly compensation shall be [$66] *$68*;

(b) if and while the disability is rated 20 percent the monthly compensation shall be [$122] *$127*;

(c) if and while the disability is rated 30 percent the monthly compensation shall be [$185] *$192*;

(d) if and while the disability is rated 40 percent the monthly compensation shall be [$266] *$276*;

(e) if and while the disability is rated 50 percent the monthly compensation shall be [$376] *$390*;

(f) if and while the disability is rated 60 percent the monthly compensation shall be [$474] *$492*;

(g) if and while the disability is rated 70 percent the monthly compensation shall be [$598] *$620*;

(h) if and while the disability is rated 80 percent the monthly compensation shall be [$692] *$718*;

(i) if and while the disability is rated 90 percent the monthly compensation shall be [$779] *$808*;

(j) if and while the disability is rated as total the monthly compensation shall be [$1,295] *$1,343*;

(k) if the veteran, as the result of service-connected disability, has suffered the anatomical loss or loss of use of one or more creative organs, or one foot, or one hand, or both but-

tocks, or blindness of one eye, having only light perception or has suffered complete organic aphonia with constant inability to communicate by speech, or deafness of both ears, having absence of air and bone conduction, the rate of compensation thereof shall be $62 per month for each such loss or loss of use independent of any other compensation provided in subsections (a) through (j) or subsection (s) of this section but in no event to exceed [$1,609] *$1,669* per month; and in the event the veteran has suffered one or more of the disabilities heretofore specified in this subsection in addition to the requirement for any of the rates specified in subsections (l) through (n) of this section, the rate of compensation shall be increased by $62 per month for each such loss or loss of use, but in no event to exceed [$2,255] *$2,338* per month;

(l) if the veteran, as the result of service-connected disability, has suffered the anatomical loss or loss of use of both feet, or of one hand and one foot, or is blind in both eyes, with 5/200 visual acuity or less or is permanently bedridden or so helpless as to be in need of regular aid and attendance, the monthly compensation shall be [$1,609] *$1,669*;

(m) if the veteran, as the result of service-connected disability, has suffered the anatomical loss or loss of use of both hands, or of both legs at a level, or with complications, preventing natural knee action with prosthesis in place, or of one arm and one leg at levels, or with complications, preventing natural elbow and knee action with prosthesis in place, or has suffered blindness in both eyes, having only light perception, or has suffered blindness in both eyes, rendering such veteran so helpless as to be in need of regular aid and attendance, the monthly compensation shall be [$1,774] *$1,840*;

(n) if the veteran, as the result of service-connected disability, has suffered the anatomical loss or loss of use of both arms at levels, or with complications, preventing natural elbow action with prosthesis in place, has suffered the anatomical loss of both legs so near the hip as to prevent the use of prosthetic appliances, or has suffered the anatomical loss of one arm and one leg so near the shoulder and hip as to prevent the use of prosthetic appliances, or has suffered the anatomical loss of both eyes, or has suffered blindness without light perception, in both eyes, the monthly compensation shall be [$2,017] *$2,092*;

(o) if the veteran, as the result of service-connected disability, has suffered disability under conditions which would entitle such veteran to two or more of the rates provided in one or more subsections (l) through (n) of this section, no condition being considered twice in the determination, or if the veteran has suffered bilateral deafness (and the hearing impairment in either one or both ears is service connected) rated at 60 percent or more disabling and the veteran has also suffered service-connected total blindness with 5/200 visual acuity or less or if the veteran has suffered service-connected total deafness in one ear or bilateral deafness (and the hearing impairment in either one or both ears is service connected) rated at 40 percent or more disabling and the veteran has also suffered serv-

ice-connected blindness having only light perception or less, or if the veteran has suffered the anatomical loss of both arms so near the shoulder as to prevent the use of prosthetic appliances, the monthly compensation shall be [$2,255] *$2,338*;

(p) in the event the veteran's service-connected disabilities exceed the requirements for any of the rates prescribed in this section, the Administrator may allow the next higher rate or an intermediate rate, but in no event in excess of [$2,255] *$2,338*. In the event the veteran has suffered service-connected blindness, with 5/200 visual acuity or less and (1) has also suffered bilateral deafness (and the hearing impairment in either one or both ears is service connected) rated at no less than 30 percent disabling, the Administrator shall allow the next higher rate, or (2) has also suffered service-connected total deafness in one ear, or service-connected anatomical loss or loss of use of one hand or one foot, the Administrator shall allow the next intermediate rate, but in no event in excess of [$2,255] *$2,338*. In the event the veteran has suffered service-connected blindness having only light perception or less, and has also suffered bilateral deafness (and the hearing impairment in either one or both ears is service connected) rated at 10 or 20 percent disabling, the Administrator shall allow the next intermediate rate, but in no event in excess of [$2,255] *$2,338*. In the event the veteran has suffered the anatomical loss or loss of use, or a combination of anatomical loss and loss of use, of three extremities, the Administrator shall allow the next higher rate or intermediate rate, but in no event in excess of [$2,255] *$2,338*. Any intermediate rate under this subsection shall be established at the arithmetic mean, rounded down to the nearest dollar, between the two rates concerned;

(r) subject to section 3203(e) of this title, if any veteran, otherwise entitled to compensation authorized under subsection (o) of this section, at the maximum rate authorized under subsection (p) of this section, or at the intermediate rate authorized between the rate authorized under subsections (n) and (o) of this section and at the rate authorized under subsection (k) of this section, is in need of regular aid and attendance, then, in addition to such compensation—

(1) the veteran shall be paid a monthly aid and attendance allowance at the rate of [$968] *$1,004; or*

(2) if the veteran, in addition to such need for regular aid and attendance, is in need of a higher level of care, such veteran shall be paid a monthly aid and attendance allowance at the rate of [$1,442] *$1,495*, in lieu of the allowance authorized in clause (1) of this subsection, if the Administrator finds that the veteran, in the absence of the provision of such care, would require hospitalization, nursing home care, or other residential institutional care.

For the purposes of clause (2) of this subsection, need for a higher level of care shall be considered to be need for personal health-care services provided on a daily basis in the veteran's home by a person who is licensed to provide such services or who provides such services under the regular supervision of a licensed health-care professional. The existence of the need for

such care shall be determined by a physician employed by the Veterans' Administration or, in areas where no such physician is available, by a physician carrying out such function under contract or fee arrangement based on an examination by such physician. For the purposes of section 334 of this title, such allowance shall be considered as additional compensation payable for disability;

(s) If the veteran has a service-connected disability rated as total, and (1) has additional service-connected disability or disabilities independently ratable at 60 percent or more, or (2) by reason of such veteran's service-connected disability or disabilities is permanently housebound, then the monthly compensation shall be [$1,449] *$1,503*. For purposes of this subsection, the requirement of "permanently housebound" will be considered to have been met when the veteran is substantially confined to such veteran's house (ward or clinical areas, if institutionalized) or immediate premises due to a service-connected disability or disabilities which it is reasonably certain will remain throughout such veteran's lifetime.

(t)(1) If the veteran (A) is entitled to receive compensation at any rate provided for under subsections (a) through (i) of this section and compensation under subsection (k) of this section, (B) has suffered the loss or loss of use of an extremity as a result of a service-connected disability ratable at 40 percent or more, and (C) has suffered the loss or loss of use of the paired extremity as a result of a non-service-connected disability, not the result of the veteran's own willful misconduct, that would be rated, if service-connected, at 40 percent or more, the monthly rate of compensation payable to such veteran shall be increased by [$280] *$290*.

(2) If a veteran described in paragraph (1) of this subsection receives any money or property of value pursuant to an award in a judicial proceeding based upon, or a settlement or compromise of, any cause of action for damages for the non-service-connected disability described in such paragraph, the increase in the rate of compensation otherwise payable under this subsection shall not be paid for any month following a month in which any such money or property is received until such time as the total of the amount of such increase that would otherwise have been payable equals the total of the amount of any such money received and the fair market value of any such property received.

§ 315. Additional compensation for dependents.

Any veteran entitled to compensation at the rates provided in section 314 of this title, and whose disability is rated not less than 30 percent, shall be entitled to additional compensation for dependents in the following monthly amounts:

(1) If and while rated totally disabled and—

(A) has a spouse but no child, [$79] *$82*;

(B) has a spouse and one or more children, [$132 plus $42] *$137 plus $44* for each child in excess of one;

(C) has no spouse but one or more children, [$54 plus $42] *$56 plus $44* for each child in excess of one;

(D) has a parent dependent upon such veteran for support, then, in addition to the above amounts, [$64] *$66* for each parent so dependent;

(E) notwithstanding the other provisions of this paragraph, the monthly payable amount on account of a spouse who is (i) a patient in a nursing home or (ii) helpless or blind, or so nearly helpless or blind as to need or require the regular aid and attendance of another person, shall be [$143] *$148* for a totally disabled veteran and proportionate amounts for partially disabled veterans in accordance with paragraph (2) of this section; and

(F) notwithstanding the other provisions of this paragraph, the monthly payable amount on account of each child who has attained the age of eighteen years and who is pursuing a course of instruction at an approved educational institution shall be [$120] *$124* for a totally disabled veteran and proportionate amounts for partially disabled veterans in accordance with paragraph (2) of this section.

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Subchapter V—Peacetime Death Compensation

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§ 362. Clothing allowance

The Administrator under regulations which the Administrator shall prescribe, shall pay a clothing allowance of [$349] *$362* per year to each veteran who because of disability which is compensable under the provisions of this chapter, wears or uses a prosthetic or orthopedic appliance or appliances (including a wheelchair) which the administrator determines tends to wear out or tear the clothing of such a veteran.

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CHAPTER 13—DEPENDENCY AND INDEMNITY COMPENSATION FOR SERVICE-CONNECTED DEATHS

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Subchapter II—Dependency and Indemnity Compensation

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§ 411. Dependency and indemnity compensation to a surviving spouse

(a) Dependency and indemnity compensation shall be paid to a surviving spouse, based on the pay grade of the person upon whose death entitlement is predicated, at monthly rates set forth in the following table:

[

Pay grade	Monthly rate	Pay grade	Monthly rate
E-1	$476	W-4	$682
E-2	490	O-1	602
E-3	502	O-2	621
E-4	535	O-3	665
E-5	549	O-4	703
E-6	561	O-5	775
E-7	589	O-6	873
E-8	621	O-7	944
E-9	[1] 649	O-8	1,035
W-1	602	O-9	1,111
W-2	626	O-10	[2] 1,217
W-3	644		

[1] If the veteran served as sergeant major of the Army, senior enlisted advisor of the Navy, chief master sergeant of the Air Force, sergeant major of the Marine Corps, or master chief petty officer of the Coast Guard at the applicable time designated by section 402 of this title, the surviving spouse's rate shall be $700.
[2] If the veteran served as Chairman of the Joint Chiefs of Staff, Chief of Staff of the Army, Chief of Naval Operations, Chief of Staff of the Air Force or Commandant of the Marine Corps, at the applicable time designated by section 402 of this title, the surviving spouse's rate shall be $1,305.

]

Pay grade	*Monthly rate*	*Pay grade*	*Monthly rate*
E-1	*$494*	*W-4*	*$707*
E-2	*508*	*O-1*	*624*
E-3	*521*	*O-2*	*644*
E-4	*555*	*O-3*	*690*
E-5	*569*	*O-4*	*729*
E-6	*582*	*O-5*	*804*
E-7	*611*	*O-6*	*905*
E-8	*644*	*O-7*	*979*
E-9	*[1] 673*	*O-8*	*1,073*
W-1	*624*	*O-9*	*1,152*
W-2	*649*	*O-10*	*[2] 1,262*
W-3	*668*		

[1] If the veteran served as sergeant major of the Army, senior enlisted advisor of the Navy, chief master sergeant of the Air Force, sergeant major of the Marine Corps, or master chief petty officer of the Coast Guard, at the applicable time designated by section 402 of this title, the surviving spouse's rate shall be $726.
[2] If the veteran served as Chairman of the Joint Chiefs of Staff, Chief of Staff of the Army, Chief of Naval Operations, Chief of Staff of the Air Force, Commandant of the Marine Corps, or Commandant of the Coast Guard, at the applicable time designated by section 402 of this title, the surviving spouse's rate shall be $1,353.

(b) If there is a surviving spouse with one or more children below the age of eighteen of a deceased veteran, the dependency and indemnity compensation paid monthly to the surviving spouse shall be increased by **[**$55**]** *$57* for each such child.

(c) The monthly rate of dependency and indemnity compensation payable to a surviving spouse shall be increased by **[**$143**]** *$148* if the spouse is (1) a patient in a nursing home or (2) helpless or blind, or so nearly helpless or blind as to need or require the regular aid and attendance of another person.

(d) The monthly rate of dependency and indemnity compensation payable to a surviving spouse shall be increased by **[**$70**]** *$73* if the surviving spouse is, by reason of disability, permanently housebound but does not qualify for the aid and attendance allowance under subsection (c) of this section. For the purposes of this subsection, the requirement of "permanently housebound" will be considered to have been met when the surviving spouse is substantially confined to such surviving spouse's home (ward or clinical areas, if

institutionalized) or immediate premises by reason of a disability or disabilities which it is reasonably certain will remain throughout such surviving spouse's lifetime.

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§ 413. Dependency and indemnity compensation to children

(a) Whenever there is no surviving spouse of a deceased veteran entitled to dependency and indemnity compensation, dependency and indemnity compensation shall be paid in equal shares to the children of the deceased veteran at the following monthly rates:

(1) one child, [$240] *$249*;

(2) two children, [$345] *$358*;

(3) three children, [$446] *$463*; and

(4) more than three children, [$446 plus $90] *$463 plus $93* for each child in excess of three.

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§ 414. Supplemental dependency and indemnity compensation to children

(a) In the case of a child entitled to dependency and indemnity compensation who has attained the age of eighteen and who, while under such age, became permanently incapable of self-support, the dependency and indemnity compensation paid monthly to such child shall be increased by [$143.] *$148*.

(b) If dependency and indemnity compensation is payable monthly to a person as a "surviving spouse" and there is a child (of such person's deceased spouse) who has attained the age of eighteen and who, while under such age, became permanently incapable of self-support, dependency and indemnity compensation shall be paid monthly to each such child, concurrently with the payment of dependency and indemnity compensation to the surviving spouse, in the amount of [$240.] *$249*.

(c) If dependency and indemnity compensation is payable monthly to a person as a "surviving spouse" and there is a child (of such person's deceased spouse) who has attained the age of eighteen and who, while under the age of twenty-three, is pursuing a course of instruction at an educational institution approved under section 104 of this title, dependency and indemnity compensation shall be paid monthly to each such child, concurrently with the payment of dependency and indemnity compensation to the surviving spouse, in the amount of [$122.] *$127*.

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CHAPTER 15—PENSION FOR NON-SERVICE-CONNECTED DISABILITY OR DEATH OR FOR SERVICE

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Subchapter II—Veterans' Pensions

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§ 525. Temporary protection of health-care eligibility

(a) In the case of a veteran whose entitlement to pension under section 521 of this title is terminated during the program period by reason of income from work or training, the veteran shall retain for a period of three years beginning on the date of such termination all eligibility for care and services under such chapter that the veteran would have had if the veteran's entitlement to pension had not been terminated. Care and services for which such a veteran retains eligibility include, when applicable, drugs and medicines under section 612(h) of this title [and special priority with respect to such care and services under section 612(i)(5) of this title.].

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

621. Power to make rules and regulations.

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625. Requirement that providers accept Medicare and Veterans' Administration beneficiaries on similar basis and accept Veterans' Administration payments as payments in full.

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Subchapter I—General

§ 601. Definitions

For the purposes of this chapter—

(1) * * *

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(4) The term "Veterans' Administration facilities" means—

(A) * * *

* * * * * * *

(C) private facilities for which the Administrator contracts when facilities described in clause (A) or (B) of this paragraph are not capable of furnishing economical care because of geographical inaccessibility or of furnishing the care or services required in order to provide (i) hospital care or medical services to a veteran for the treatment of a service-connected disability or a disability for which a veteran was discharged or released from the active military, naval, or air service; (ii) medical services for the treatment of any disability of a veteran described [in clause (1)(B) or (2) of the first sentence, or in the third sentence,] *in paragraph (1)(A)(ii), (1)(B), or (1)(C)* of sec-

tion 612(f) of this title or of a veteran described in section 612(g) of this title if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in facilities described in clauses (A) and (B) of this paragraph; (iii) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a facility described in clause (A) or (B) of this paragraph until such time as the veteran can be safely transferred to any such facility; (iv) hospital care for women veterans; (v) hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State not contiguous to the forty-eight contiguous States, except that the annually determined hospital patient load and incidence of the provision of medical services to veterans hospitalized or treated at the expense of the Veterans' Administration in Government and private facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by the Veterans' Administration within the forty-eight contiguous States, but the authority of the Administrator under this subclause (except with respect to Alaska and Hawaii) shall expire on September 30, 1985, and until such date the Administrator may, if necessary to prevent hardship, waive the applicability to the Commonwealth of Puerto Rico and to the Virgin Islands of the restrictions in this subclause with respect to hospital patient loads and incidence of provision of medical services; or (vi) diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, the provision of medical services at independent Veterans' Administration outpatient clinics to obviate the need for hospital admission.

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(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services—

(A)(i) surgical services, dental services and appliances as described in sections 610 and 612 of this title, optometric and podiatric services (in the case of a person otherwise receiving care or services under this chapter), preventive health-care services as defined in section 662 of this title, and (except under the conditions described in section [612(f)(1)(A)] *612(f)(1)(A)(i)* of this title), wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Administrator determines to be reasonable and necessary, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

(B) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

(i) * * *

(ii) in the discretion of the Administrator, of the non-service-connected disability of a veteran eligible for treatment under section [612(f)(1)(B)] *612(f)(1)(A)(ii)* of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital,

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Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical Treatment

§ 610. Eligibility for hospital, nursing home, and domiciliary care

[(a) The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to—

[(1)(A) any veteran for a service-connected disability; or

[(B) any veteran for a non-service-connected disability if such veteran is unable to defray the expenses of necessary hospital or nursing home care;

[(2) a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty;

[(3) a person (A) who is in receipt of, or but for the receipt of retirement pay would be entitled to disability compensation, or (B) who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such person's continuing eligibility for such care is provided for in the judgment or settlement desired in such section;

[(4) a veteran who is a former prisoner of war;

[(5) a veteran who meets the conditions of subsection (e) of this section; and

[(6) any veteran for a non-service-connected disability if such veteran is sixty-five years of age or older.]

(a) The Administrator shall furnish hospital care which the Administrator determines is needed and may (within the limits of Veterans' Administration facilities) furnish nursing home care which the Administrator determines is needed—

(1) to any veteran for a service-connected disability;

(2) to a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty, for any disability;

(3) to a veteran who is in receipt of, or but for the receipt of retirement pay would be entitled to disability compensation, for any disability;

(4) to a veteran who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for

such care is provided for in the judgment or settlement described in such section, for any disability;

(5) to a veteran as provided in subsection (e) of this section;

(6) to a veteran who is a former prisoner of war, for any disability;

(7) to a veteran of the Spanish-American War, Indian wars, Mexican border period, or World War I, for any disability;

(8) to a veteran for a non-service-connected disability, if the veteran is unable to defray the expenses of necessary care; and

(9) to a veteran for a non-service-connected disability if, in the case of hospital care (as well as nursing home care), the Administrator determines that the care may be provided within the limits of Veterans' Administration facilities.

* * * * * * *

(e)(1)(A) Subject to paragraphs (2) and (3) of this subsection, a veteran—

(i) who served on active duty in the Republic of Vietnam during the Vietnam era, and

(ii) who the Administrator finds may have been exposed during such service to dioxin or was exposed during such service to a toxic substance found in a herbicide or defoliant used in connection with military purposes during such era,

[may be furnished hospital care or] *shall be furnished hospital care and may (within the limits of Veterans' Administration facilities) be furnished* nursing home care under subsection (a)(5) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such diability may be associated with such exposure.

(B) Subject to paragraphs (2) and (3) of this subsection, a veteran who the Administrator finds was exposed while serving on active duty to ionizing radiation from the detonation of a nuclear device in connection with such veteran's participation in the test of such a device or with the American occupation of Hiroshima and Nagasaki, Japan, during the period beginning on September 11, 1945, and ending on July 1, 1946, [may be furnished hospital care or] *shall be furnished hospital care and may (within the limits of Veterans' Administration facilities) be furnished* nursing home care under subsection (a)(5) of this section for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

* * * * * * *

(f)(1) Except as provided in paragraph (2) of this subsection, the Administrator may not furnish hospital care or nursing home care under this section to a veteran who is eligible for such care solely because of subsection (a)(9) of this section unless the veteran agrees to pay to the United States the lesser of—

(A) the cost of furnishing such care, as determined by the Administrator; and

(B) the amount of the inpatient Medicare deductible in effect on the date of the veteran's admission for such care.

(2) A veteran may not be required to make a payment under paragraph (1) of this subsection for care furnished during any 12-month

period to the extent that such payment would cause the total amount paid by the veteran under such paragraph for hospital and nursing home care furnished during that period and under section 612(f)(3) of this title for medical services furnished during that period to exceed the amount of the inpatient Medicare deductible in effect for services provided during the first month of such 12-month period.

(3) An amount collected or received by the Veterans' Administration under this subsection shall be deposited in the Treasury as a proprietary receipt.

(4) For the purposes of this subsection, the term "inpatient Medicare deductible" means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)).

(g) Nothing in this section—

(1) requires the Administrator to furnish hospital care in a facility other than a Veterans' Administration facility;

(2) requires the Administrator to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty to provide care in an institution of such government; or

(3) restricts the Administrator's discretion to determine—

(A) the appropriateness of furnishing medical services, therapies, or programs under this chapter; or

(B) in what manner they will be furnished.

* * * * * * *

§ 612. Eligibility for medical treatment

(a) Except as provided in subsection (b) of this section, the Administrator[, within the limits of Veterans' Administration facilities, may] *shall* furnish such medical services as the Administrator finds to be reasonably necessary to any veteran for a service-connected disability. The Administrator may also furnish to any such veteran such home health services as the Administrator finds to be necessary or appropriate for the effective and economical treatment of such disability (including only such improvements and structural alterations the cost of which does not exceed $2,500 (or reimbursement up to such amount) as are necessary to assure the continuation of treatment for such disability or to provide access to the home or to essential lavatory and sanitary facilities). In the case of any veteran discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, such services may be so furnished for that disability, whether or not service-connected for the purposes of this chapter.

* * * * * * *

(f) [The Administrator, within the limits of Veterans' Administration facilities, may] *(1) Except as provided in paragraph (3) of this subsection, the Administrator shall* furnish medical services for any disability on an outpatient or ambulatory basis—

[(1)] *(A)* to any veteran eligible for hospital care under section 610 of this title [A] *(i)* where such services are reasonably necessary in preparation for, or (to the extent that facilities are available) to obviate the need of, hospital admission, or

[(B)] *(ii)* where such a veteran has been furnished hospital care and such medical services are reasonably necessary to complete treatment incident to such hospital care (for a period not in excess of twelve months after discharge from in-hospital treatment, except where the Administrator finds that a longer period is required by virtue of the disability being treated);

[(2)] *(B)* to any veteran who has a service-connected disability rated at 50 percent or more; and

[(3)] *(C)* to any veteran who is a former prisoner of war.

(2) The Administrator may also furnish to any such veteran such home health services as the Administrator determines to be necessary or approrpriate for the effective and economical treatment of a disability of a veteran (including only such improvements and structural alterations the cost of which does not exceed $600 (or reimbursement up to such amount) as are necessary to assure the continuation of treatment or provide access to the home or to essential lavatory and sanitary facilities). [The Administrator may also furnish outpatient dental services and treatment, and related appliances, to any veteran described in clause (G) of subsection (b)(1) of this section.]

(3)(A) The Administrator may not furnish medical services under paragraph (1) of this subsection or home health services under paragraph (2) of this subsection to a veteran who is eligible for such care solely because of section 610(a)(9) of this title unless the veteran agrees to pay the United States, in the case of each visit in which such medical or home health services are furnished, the amount equal to 20 percent of the estimated average cost of an outpatient visit a Veterans' Administration facility during the fiscal year in which the services are furnished. Such estimated average cost shall be determined by the Administrator.

(B) Subparagraph (A) of this paragraph does not apply to services furnished under paragraph (1)(A)(ii) of this subsection.

(C) A veteran may not be required to make a payment under this paragraph for services furnished under this subsection during any 12-month period to the extent that such payment would cause the total amount paid by the veteran under this paragraph for medical services furnished during that period and under section 610(f) of this title for hospital and nursing home care furnished during that period to exceed the amount of the inpatient Medicare deductible in effect for services provided during the first month of such 12-month period.

(D) For the purposes of this paragraph, the term "inpatient Medicare deductible" means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)).

(E) An amount collected or received by the Veterans' Administration under this paragraph shall be deposited in the Treasury as a proprietary receipt.

(g) In the case of any veteran who is a veteran of the Mexican border period or of World War I or who is in receipt of increased pension of additional compensation or allowance based on the need of regular aid and attendance or by reason of being permanently housebound, or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance, the Adminis-

trator [, within the limits of Veterans' Administration facilities, may] *shall* furnish the veteran such medical services as the Administrator finds to be reasonably necessary. The Administrator may also furnish to any such veteran home health services under the terms and conditions set forth in subsection (f) of this section.

* * * * * * *

[(i) The Administrator shall prescribe regulations to ensure that special priority in furnishing medical services under this section and any other outpatient care with funds appropriated for the medical care of veterans shall be accorded in the following order, unless compelling medical reasons require that such care be provided more expeditiously:

[(1) To any veteran for a service-connected disability.

[(2) To any veteran described in subsection (f)(2) of this section.

[(3) To any veteran for a disability rated as service-connected (including any veteran being examined to determine the existence or rating of a service-connected disability).

[(4) To any veteran (A) who is a former prisoner of war, or (B) who is eligible for care under section 610(a)(5) of this title.

[(5) To any veteran being furnished medical services under subsection (g) of this section.]

(j) In order to assist the Secretary of Health and Human Services in carrying out national immunization programs [pursuant to] *under* other provisions of law, the Administrator may authorize the administration of immunizations to eligible veterans [voluntarily requesting] *who voluntarily request* such immunizations] in connection with the provision of care for a disability under this chapter in any Veterans' Administration health care [facility, utilizing] *facility. Any such immunization shall be made using* vaccine furnished by the Secretary at no cost to the Veterans' [Administration, and for such purpose, notwithstanding any other provision of law, the Secretary is authorized to provide] *Administration. For such purpose, the Secretary may provide* such vaccine to the Veterans' Administration at no [cost and the provisions of section] *cost. Section* 4116 of this title shall apply to claims alleging negligence or malpractice on the part of Veterans' Administration personnel granted immunity under such section.

§ 612A. Eligibility for readjustment counseling and related mental health services

(a) * * *

(b)(1) If, on the basis of the assessment furnished under subsection (a) of this section, a physician or psychologist employed by the Veterans' Administration (or, in areas where no such physician or psychologist is available, a physician or psychologist carrying out such function under a contract or fee arrangement with the Administrator) determines that the provision of mental health services of such veteran is necessary to facilitate the successful readjustment of the veteran to civilian life, such veteran shall, within the limits of Veterans' Administration facilities, be furnished such services on an outpatient basis under the conditions specified in [clause (1)(B)] *paragraph (1)(A)(ii)* of section 612(f) of this title. For

the purposes of furnishing such mental health services, the counseling furnished under subsection (a) of this section shall be considered to have been furnished by the Veterans' Administration as a part of hospital care. Any hospital care and other medical services considered necessary on the basis of the assessment furnished under subsection (a) of this section shall be furnished only in accordance with the eligibility criteria otherwise set forth in this chapter (including the eligibility criteria set forth in section 611(b) of this title).

* * * * * * *

(e)(1) In furnishing counseling and related mental health services under subsections (a) and (b) of this section, the Administrator shall have available the same authority to enter into contracts with private facilities that is available to the Administrator (under sections [612(f)(2)] *612(f)(1)(B)* and 601(4)(C)(ii) of this title) in furnishing medical services to veterans suffering from total service-connected disabilities.

* * * * * * *

§ 618. Therapeutic and rehabilitative activities

(a) * * *

* * * * * * *

[(e) The Administrator shall prescribe regulations to ensure that the priorities set forth in section 612(i) of this title shall be applied, insofar as practicable, to participation in therapeutic and rehabilitation activities carried out under this section.]

* * * * * * *

§ 620. Transfers for nursing home care; adult day health care

(a) * * *

* * * * * * *

(f)(1)(A) The Administrator is authorized to furnish adult day health care as provided for in this subsection. For the purpose only of authorizing the furnishing of such care and specifying the terms and conditions under which it may be furnished to veterans needing such care—

(i) * * *

(ii) a veteran who is eligible for medical services under section [612(f)(2)] *612(f)(1)(B)* of this title shall be deemed to be a veteran described in subsection (a)(1) of this section.

* * * * * * *

Subchapter III—Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

* * * * * * *

§ 622. Evidence of inability to defray necessary expenses

(a) For the purposes of sections [610(a)(1)(B),] *610(a)(8)*, 610(b)(2), 624(c) and 632(a)(2) of this title, the fact that an individual is—

(1) eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(2) a veteran with a service-connected disability; or

(3) in receipt of pension under any law administered by the Veterans' Administration;

(b)(1) An individual who does not qualify as having sufficient evidence of inability to defray necessary expenses by reason of subsection (a) of this section shall nevertheless be presumed to be unable to defray necessary expenses for the purpose of the sections referred to in that subsection if the individual's attributable income during the 12-month period preceding the date of the individual's application for care under one of those sections is not greater than the health-care income threshold.

(2) Notwithstanding paragraph (1) of this subsection, the Administrator may refuse to determine that an individual is unable to defray necessary medical expenses for the purpose of the sections referred to in subsection (a) of this section if the corpus of the estate of the individual (and of the individual's spouse and dependent children, if any) is such that under all the circumstances (including consideration of the annual income of the individual and of such spouse and dependent children) it is reasonable that some part of the corpus of such estates be consumed for the individual's maintenance.

(3) For purposes of this subsection, an individual's attributable income shall be determined in the same manner as the manner in which a determination is made of the total amount of income by which the rate of pension for such individual under section 521 of this title would be reduced if such individual were eligible for pension.

(4) For purposes of paragraph (1) of this subsection, the health-care income threshold for an individual—

(A) in the case of an application for care made during the 12-month period beginning on December 1, 1985, is the amount equal to the product of—

(i) 3.34, and

(ii) the applicable current maximum annual rate of pension (as determined under paragraph (5) of this subsection); and

(B) in the case of an application for care made during a 12-month period beginning on December 1 of a calendar year after 1985, is the amount in effect for purposes of this paragraph during the previous 12-month period increased by the percentage by which benefits have been increased under section 3112(a) of this title during that period.

(5) For purposes of paragraph (4)(A)(ii) of this subsection, the current maximum annual rate of pension for a veteran is—

(A) the amount in effect under section 521(b) in the case of a veteran who is unmarried (or married but not living with or reasonably contributing to the support of such veteran's spouse)

and there is no child of the veteran in the custody of the veteran or to whose support the veteran is reasonably contributing; and

(B) the amount in effect under section 521(c), in the case of a veteran who is married and living with or reasonably contributing to the support of such veteran's spouse or if there is a child of the veteran in the veteran's custody or to whose support the veteran is reasonably contributing.

* * * * * * *

§ 625. Requirement that providers accept Medicare and Veterans' Administration beneficiaries on similar basis and accept Veterans' Administration payments as payments in full

(a) A non-Federal provider of hospital services to any Medicare beneficiary—

(1) must accept Veterans' Administration beneficiaries on a similar basis; and

(2) must accept payments made by the Administrator in accordance with Veterans' Administration regulations as payments in full.

(b) Upon a finding by the Administrator, made in accordance with procedures developed in consultation with the Secretary of Health and Human Services, that a Medicare provider has failed to comply with subsection (a) of this section, the Administrator shall report such finding to the Secretary for possible corrective action or for possible termination of the provider's agreement with the Secretary entered into under the Social Security Act (42 U.S.C. 1395cc(a)). Thereafter, in addition to the bases for termination set forth in such Act, the Secretary may terminate such agreement with the provider if the Secretary determines that the provider has failed to comply with this section.

(c) For purposes of this section, the term "Veterans' Administration beneficiaries" means all veterans and other persons for whose hospital care outside Federal facilities the Administrator is authorized to pay.

* * * * * * *

[§ 629. Recovery by the United States of the cost of certain care and services

[(a) In any case in which a veteran is furnished care and services under this chapter for a non-service-connected disability that was incurred—

[(1) incident to the veteran's employment and the disability is covered under a workers' compensation law or plan that provides reimbursement for or indemnification of the cost of health care and services provided to the veteran by reason of the disability,

[(2) as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations insurance, or

[(3) as the result of a crime of personal violence that occurred in a State, or a political subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such crime,

the United States has the right to recover the reasonable costs of such care and services from the State, or political subdivision of a State, employer, employer's insurance carrier, or automobile accident preparations insurance carrier, as appropriate, to the extent that the veteran, or the provider of care and services to the veteran, would be eligible to receive reimbursement or indemnification for such care and services if the care and services had not been furnished by a department or agency of the United States.

[(b) The amount that may be recovered by the United States under subsection (a) of this section may not exceed the lesser of (1) an amount equal to the reasonable cost of the care and services furnished the veteran under this chapter, as determined by the Administrator, or (2) the maximum amount specified by the law of the State or political subdivision concerned or by any relevant contractual provision to which the veteran was a party or was subject. The Administrator shall prescribe regulations for the determination of the reasonable cost of care and services under clause (1) of the preceding sentence, and any determination of such reasonable value by the Administrator under such clause shall be made in accordance with such regulations. Regulations under the preceding sentence shall be prescribed only after notice and opportunity for public comment.

[(c)(1) The United States shall, as to the right provided in subsection (a) of this section, be subrogated to any right or claim that the veteran or the veteran's personal representative, successor, dependents, or survivors may have against a State or political subdivision of a State, an employer, an employer's insurance carrier, or an automobile accident reparations insurance carrier.

[(2)(A) In order to enforce any right or claim to which it is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by the veteran or the veteran's personal representative, successor, dependents, or survivors against a State or political subdivision of a State, an employer, an employer's insurance carrier, or an automobile accident reparations insurance carrier.

[(B) If—

[(i) no such action or proceeding has been commenced within one hundred and eighty days after the first day on which care and services for which recovery is sought were furnished to the veteran by the Veterans' Administration under this chapter, and

[(ii) the United States has sent written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute legal proceedings,

the United States may, sixty days after the mailing of such notice, institute and prosecute legal proceedings against the State, politi-

cal subdivision, employer, employer's insurance carrier, or automobile accident reparations insurance carrier.

[(d) A veteran eligible for care and services under this chapter may not be denied such care and service by reason of this section.

[(e) No law of any State or of any political subdivision of a State, and no provision of any contract or agreement entered into, renewed, or modified under any State law, shall operate to prevent recovery by the United States (1) under subsection (a) of this section for care and services furnished under this chapter to any veteran for a non-service-connected disability, or (2) under section 611(b) of this title for care and services furnished under such section to an individual as a humanitarian service in an emergency case.]

§629. Recovery by the United States of the cost of certain care and services

(a)(1) In any case in which a veteran is furnished care or services under this chapter for a disability described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable costs of such care or services (as determined by the Administrator under subsection (d)(2)) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive reimbursement or indemnification for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

(2) Paragraph (1) of this subsection applies to a non-service-connected disability—

(A) that is incurred incident to the veterans' employment and that is covered under a workers' compensation law or plan that provides reimbursement for or indemnification of the cost of health care and services provided to the veteran by reason of the disability;

(B) that is incurred as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations insurance;

(C) that is incurred as the result of a crime of personal violence that occurred in a State, or a political subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such crime; or

(D) that is incurred by a veteran who—

(i) does not have a service-connected disability; and

(ii) is entitled to care (or reimbursement for the expenses of care) under an insurance policy, contract, medical, or hospital service agreement, membership, or subscription contract, or similar arrangement for the purpose of providing, paying for, or reimbursing expenses for health services.

(b)(1) With respect to the right provided in subsection (a) of this section, the United States shall be subrogated to any right or claim that the veteran (or the veteran's personal representative, successor, dependents, or survivors) may have against a third party.

(2)(A) In order to enforce any right or claim to which it is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by the veteran (or the veteran's personal representative, successor, dependents, or survivors) against a third party.

(B) The United States may institute and prosecute legal proceedings against the third party if—

(i) an action or proceeding described in subparagraph (A) of this paragraph is not begun within 180 days after the first day on which care and services for which recovery is sought are furnished to the veteran by the Veterans' Administration under this chapter;

(ii) the United States sends written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute such legal proceedings; and

(iii) a period of 60 days has passed following the mailing of such notice.

(c) The Administrator may compromise, settle, or waive a claim of the United States under this section.

(d)(1) The Administrator may enter into contracts or agreements with individuals or organizations for services to recover or collect amounts due the United States under this section. Notwithstanding section 3302(b) of title 31, such a contract or agreement may provide that a fee an individual or organization charges to recover or collect amounts due the United States is payable from the amount recovered or collected. Any such contract or agreement shall provide that—

(A) the Administrator retains the authority to—

(i) resolve a dispute;

(ii) compromise a claim;

(iii) end collection action; and

(iv) refer a matter to the Attorney General to bring civil action; and

(B) with respect to any such recovery or collection, the individual or organization is subject to—

(i) section 552a(m) of title 5 and sections 3301 and 4132 of this title; and

(ii) laws and regulations of the United States and of the States related to collection practices.

(2) The amount that may be recovered by the United States under subsection (a) of this section may not exceed the lesser of—

(A) an amount equal to the reasonable cost of the care and services furnished the veteran under this chapter, as determined by the Administrator; or

(B) the maximum amount specified (as applicable)—

(i) by the law of the State or political subdivision concerned; or

(ii) by any relevant contractual provision to which the veteran was a party or was subject.

(3) For the purpose of determining the reasonable cost of care and services under subsection (a)(1) of this section and paragraph (2)(A) of this subsection, the Administrator—

(A) shall prescribe regulations; and

(B) may enter into agreements with insurance, medical service, and health-plan carriers and contractors.

(4) Regulations prescribed under paragraph (3) of this subsection shall be prescribed only after notice and opportunity for public comment.

(5) A determination for the purposes of this subsection of the reasonable cost of care and services furnished a veteran under this chapter shall be made in accordance with regulations prescribed and agreements entered into under paragraph (3) of this subsection.

(e) A veteran eligible for care or services under this chapter may not be denied such care or services by reason of this section.

(f) No law of any State or of any political subdivision of a State, and no provision of any contract or other agreement entered into, renewed, or modified (including any modifications of premiums or coverage) after the date of the enactment of the Veterans' Health-Care Eligibility Reform Act of 1985, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under section 611(b) of this title.

(g) Any moneys collected or received by the Veterans' Administration under this section shall be deposited in the Treasury as a proprietary receipt.

(h) The Administrator shall make available clinical records of the Veterans' Administration for a veteran who is a beneficiary of any kind of policy, contract, agreement, or other arrangement which is referred to in subsection (a)(2)(D) of this section and with respect to which recovery or collection is sought under this section for inspection and review by the parties to such policy, contract, agreement, or other arrangement for the sole purpose of permitting such parties to verify that services for which recovery or collection is sought were furnished.

(i)(1) For purposes of this section, the term "third party" means—

(A) a State or political subdivision of a State;

(B) an employer or an employer's insurance carrier;

(C) an automobile accident reparations insurance carrier;

(D) an insurance, medical service, or health plan carrier; or

(E) a contractor.

(2) Such term does not include—

(A) the insurance programs under parts A and B of title XVIII of the Social Security Act; or

(B) a State plan for medical assistance approved under title XIX of such Act.

* * * * * * *

Subchapter VII—Preventive Health-Care Services Pilot Program

* * * * * * *

§ 663. Preventive health-care services

(a)(1) In order to carry out the purpose of this subchapter, the Administrator, within the limits of Veterans' Administration facilities and in accordance with regulations which the Administrator shall prescribe, shall during fiscal years 1984 through 1988, furnish

to any veteran described in section [612(f)(2)] *612(f)(1)(B)* of this title otherwise being furnished care or services under this chapter, and to any veteran receiving care or services under this chapter involving a service-connected disability, such preventive health-care services as the Administrator determines are feasible and appropriate. In carrying out the pilot program under this subchapter, the Administrator may furnish such preventive health-care services to any other veteran described in section [612(f)(2)] *612(f)(1)(B)* of this title.

* * * * * * *

SUPPLEMENTAL VIEWS: H.R. 1538, AS AMENDED

H.R. 1538, as amended, represents a package of actions taken to meet reconciliation savings targets imposed by the Congress of $300 million in fiscal year 1986. I have opposed proposals to implement a means test and third party reimbursement for Veterans' Administration medical care. I have long been concerned about deficits, but there were several reasons for my not supporting these proposals. Chief among those reasons was the inability of the VA to provide details of the impact of the anticipated savings.

With regard to the third party recovery authority, I have consulted closely with representatives of various third-party insurers and others with an interest in the legislation. As a result of these consultations, I offered and the Committee agreed to clarifications on two points. The first point is about how the costs of VA medical care are to be established by the VA. Specifically, the VA may use either the regulatory process with public review and comment or may enter into contracts or agreements with third parties to establish reasonable costs. In either event, the way the costs are established should be open and clear. The second point is the extent that such costs could be recovered from third parties. No third party payor would be required to reimburse the VA for the cost of a health care service that is not covered under the terms and conditions of their contracts or agreements with the veteran patient. Except for the provisions which invalidate insurance contract exclusionary clauses banning payment for VA care, all other provisions of an insured veteran's health insurance contract will be applicable in any situation in which the VA is seeking to recover the cost of care provided to the veteran. Thus, to the extent that insurance contracts have provisions requiring preadmission screening or utilization review requirements, or any other such elements, the VA, if it seeks to collect under contracts, will have to comply in a similar fashion as a non-VA entity.

With regard to the means test, in my judgment, it is still not clear what the savings will really be; it is still not clear what the impact will be on other federal programs such as Medicaid and Medicare due to demands for care from veterans made ineligible by the means test; it is still not clear what the impact will be on private insurers and the rest of the American health system; and it is still not clear what the impact will be on veterans themselves.

In addition to clarifying the specific items in the third party reimbursement provision that I have discussed and in consideration of my doubts about the means test provision, I proposed and the committee agreed to a report on the implementation of these policy changes. This report will include, but not be limited to, the following: first, the number of veterans receiving health care from the VA during the report period, including the existence and extent of policies, contracts, or other arrangements with third parties for the

purpose of providing, paying for, or reimbursing expenses for health services; second, the number of veterans applying for health care from the VA during the report period, including the existence and extent of third party reimbursement arrangements and reasons why veterans who applied for care did not receive it. I did not intend when I offered this provision, nor did the Committee on Veterans' Affairs intend, that an elaborate or costly data collection system be set up. This report is to be derived from management information only. The cost of the report as projected by the CBO is the cost that is routinely incurred as program operations expenses.

There is one final feature about these provisions that is salient. This is a provision that I developed, Mr. Montgomery, Chairman of the full Committee and John Paul Hammerschmidt, ranking minority member, agreed to and that was accepted by the Committee. It is most important as it provides a sunset clause which would terminate the health care eligibility reform provisions after three years unless the Congress acts to extend them.

I voted against the package of provisions at our Committee markup even though I sincerely believe that my amendments improved it. I wish that the Members of the House could have had the opportunity to vote on these major changes to VA health care eligibility separate from the rest of H.R. 1538, as amended. That opportunity was not afforded. Therefore, I wanted to record my continuing reservations about these changes to VA health care eligibility.

BOB EDGAR, *Chairman,*
Subcommittee on Hospitals and Health Care.

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